

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper and send it to the funeral home. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician's name must be marked at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 3 8

1. DECEASED NAME (TYPE OR PRINT)		FIRST Irene	MIDDLE Dot	LAST Acree	2a. DATE OF DEATH		MONTH 5	DAY 29	YEAR 87	2b. HOUR		12:55P M
3. SEX	Female		4. RACE	white		5. DATE OF BIRTH	MONTH 9	DAY 23	YEAR 1899	6. AGE (IN YEARS LAST BIRTHDAY)	87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia		7b. CITIZEN OF WHAT COUNTRY?	USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt. C. Co. MD					
10. CITY OR TOWN OF DEATH	Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			
MD			BALTIMORE			Balt.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE			21225			
Alexander Talley			Gorsin Argonbright			515 Annabell Ave.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
NO			218 104422			Mr. John E. Elley			226 Olen Dr., 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>arrhythmia</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Warshawsky</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/29/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Warshawsky						22e. ADDRESS South Baltimore General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			6/1/1987		Cedar Hill Cemetery		Balto., A.A. Co., Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE AND BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McCully Funeral Homes Balto., Md. 21225						JUN 1 1987		Julia Gordon-Randall				

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-13239
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ava L. Adams		2a. DATE OF DEATH MONTH DAY YEAR 5/11/87		2b. HOUR MIN. 8:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1892	
6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3638 Old York Rd. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST William Grayson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Sharpe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-34-2160		17. INFORMANT ADDRESS Evelyn A. Duggins 3638 Old York Rd. 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) septic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular thrombosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5/11/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/11/87 to 5/11/87 , that (I) (we) last saw the deceased alive on 5/11/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Marcos B. Galicia Jr. MD		DEGREE MD		22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA, Jr. MD		22e. ADDRESS North Charles Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 14 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 13 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall	

Adams

Jan. 21, 1914

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North Carolina General

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 13240

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE R ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 05 06 87		2b. HOUR 9:20 A.M.
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 07 08 35		6. AGE (IN YEARS LAST BIRTHDAY) 51	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY BALD. CITY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2717 FISK RD. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Tripp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-345855		17. INFORMANT Angela Hall	
				ADDRESS 2239 Sidney Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CEREBRAL HERNIATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). SUBARACHNOID HEMORRHAGE from CEREBRAL ARTERIAL ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (c). MALIGNANT HYPERTENSION					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 2, 1987, to MAY 6, 1987, that (I) (we) last saw the deceased alive on MAY 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Brian K. Flowers		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN K. FLOWERS		22e. ADDRESS 22 S. GREENE ST. BALD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/11/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C. March F/H West		ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR MAY 12 1987	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

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BP

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MD

Disposal

Water

Tip

Case

Time

No

Capital Hall

2001 2nd Ave

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

1 3 2 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen L. Aichler		2a. DATE OF DEATH MONTH DAY YEAR May 1 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 30 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 S. Anne Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Dinsmore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Nelson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT ADDRESS 21221 Elsie Barnabae 15 D Glenwood Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>May</u> 19 <u>86</u> to <u>April</u> 19 <u>88</u> that (I) (we) last saw the deceased alive on <u>April</u> 19 <u>88</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE <u>A. B. Paulino</u>		DEGREE <u>md</u>	22c. DATE SIGNED <u>5/4/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Adonacion B. Paulino</u>		22e. ADDRESS <u>300 South Conkling Bldg. Md 21224</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/5/87	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	23d. LOCATION CITY OR TOWN Baltimore	STATE Md.
24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc.		25a. DATE REC'D. BY REG. CLERK MAY 5 1987		
ADDRESS 21231 1901 Eastern Ave.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

RECEIVED

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WV

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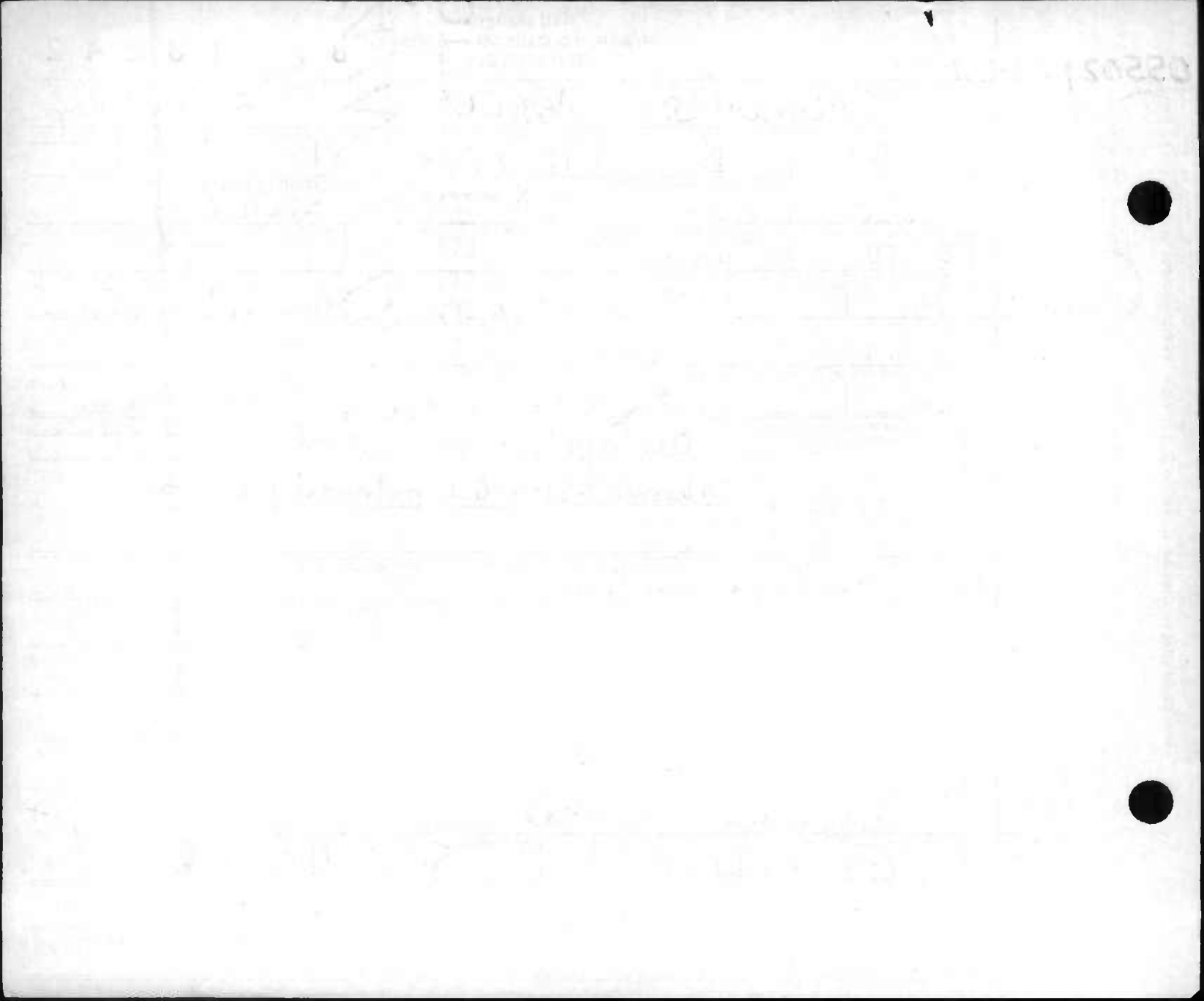


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13242

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CLINTON S. AGNEW		2a. DATE OF DEATH MONTH DAY YEAR 5 23 87		2b. HOUR 420 P.M.	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 23 05		6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13e. STREET ADDRESS / ZIP CODE			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN - Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Agnew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes			
16b. SOCIAL SECURITY NO. 219-12-6649		17. INFORMANT June Agnew		ADDRESS 3802 Woodhaven Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Multiple myeloma</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> 19 <u>87</u> to <u>5/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Galarra		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GALARARRAGA		22e. ADDRESS Sinai Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/1/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue				25. DATE REC'D. BY REGISTRAR JUN 1 1987			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Robert							



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G-627 Item 9 Per F.H. by S.B.

FOR
STATE
REGISTRAR 5-8-87STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 2 4 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILBERT ALDERMAN			2a. DATE OF DEATH MONTH DAY YEAR 4-16-87		2b. HOUR 2:10 PM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 05 25 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 450 Cummings Ct. 21201	
14. FATHER'S NAME FIRST MIDDLE LAST Tom Alderman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Alderman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 244-18-6614		17. INFORMANT ADDRESS Pearl Foster 833 W. Pratt St. Apt. 516 (01)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA LARYNX DUE TO, OR AS A CONSEQUENCE OF (b) CA LARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 7 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H/O ETOH abuse					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-11 , 19 87 , to 4-16 , 19 87 , that (I) (we) lost saw the deceased alive on 4-9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. Vicioso, MD		DEGREE MD		22c. DATE SIGNED 4-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Vicioso, MD		22e. ADDRESS 22 S. Greene St. Balt MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/22/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA			1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR APR 21 1987
			25b. REGISTRAR'S SIGNATURE <i>Julia T. ...</i>		

BP

(57)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 2 4 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TREVINA L. ALSTON		2a. DATE OF DEATH MONTH DAY YEAR 5 1 87		2b. HOUR M	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2 16 73		6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST William Smyre		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janice Carter		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-84-1889		17. INFORMANT ADDRESS Janice Carter Smyre 5516 Fernpark Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia (Presumed) DUE TO, OR AS A CONSEQUENCE OF (c) Aplastic Anemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FEB. 19 87, to May 1, 19 87, that (I) (we) lost saw the deceased alive on 5/1/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Allen D. Schwartz, M.D.		DEGREE		22c. DATE SIGNED 5/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALLEN D. SCHWARTZ, MD.		22e. ADDRESS UNIV. MD. HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/87		23c. NAME OF CEMETERY OR CREMATORY Garden Of Eternal Hope	
23d. LOCATION CITY OR TOWN Finksbury		COUNTY Md		23e. DATE REC'D. BY REGISTRAR MAY 6 1987	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue		24b. REGISTRAR'S SIGNATURE Julia Anderson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

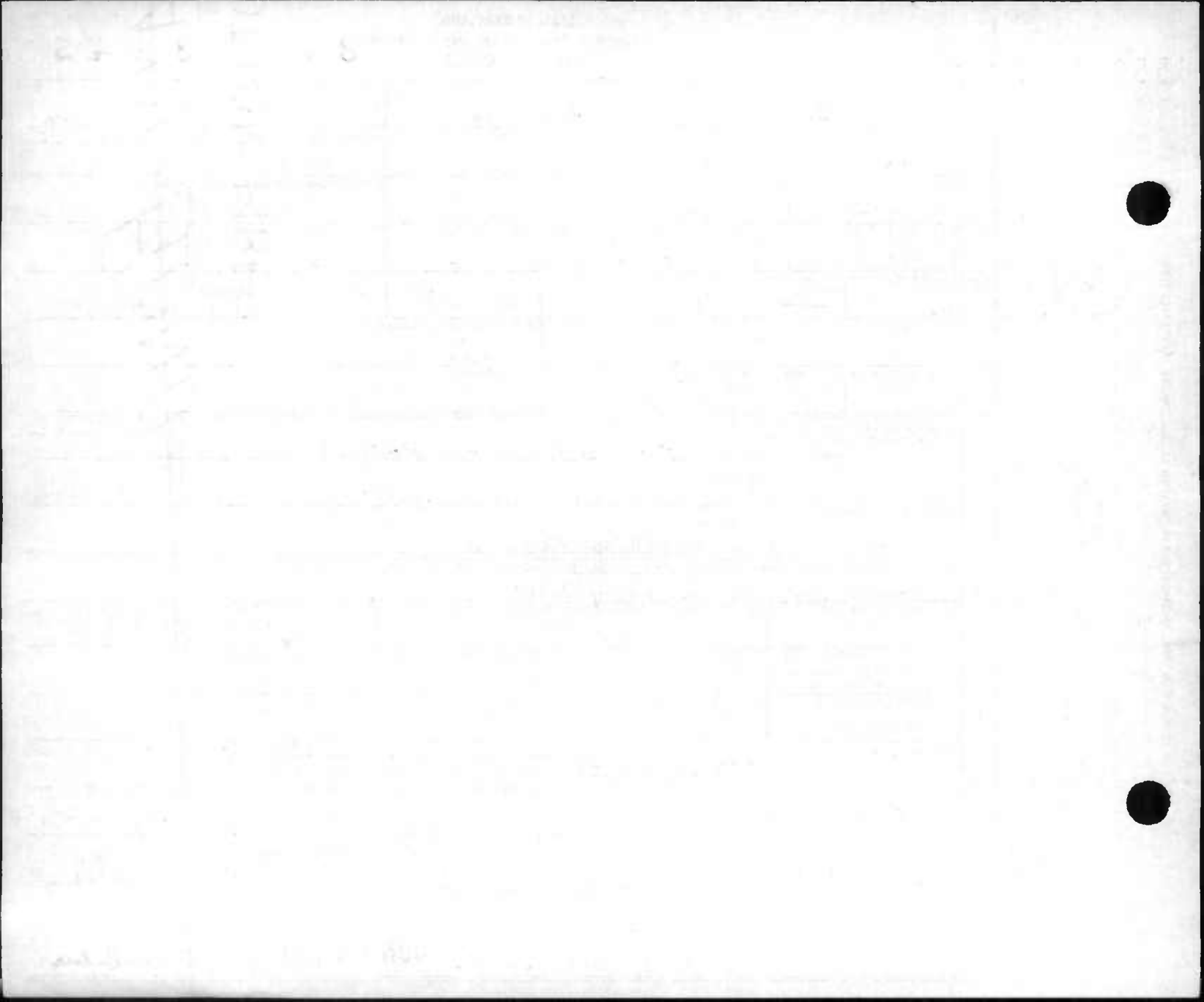
13245

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST John Ambrose		MONTH DAY YEAR 5 27 87		6:50 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR 1 24 26		61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	U.S.			Balto. City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balto.	North Charles Gen. Hosp.		Coast Guard		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.			Balto.	YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST Ambrose		FIRST MIDDLE LAST Anna		3207 St. Paul St. 21218	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WWII and Korean		706-07-5018	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>Congestive cardiac failure</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>CIRRHOSIS OF LIVER</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
<u>CHRONIC obstructive Pulmonary disease.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>MAY 27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Pareesh C. Patel</u>				<u>May 27 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>PARESH C. PATEL</u>		<u>Dept. of Medicine</u> <u>Wynnan Park Medical Center, 21211</u> MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Removal		5-29-87			CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS State Anatomy Board Balto., Md.		JUN 02 1987		<u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1, add 2, then file in the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 340.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the deceased has been pronounced dead, it should be detached for use as the burial-transit permit. Then please remove carbon pages, register, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

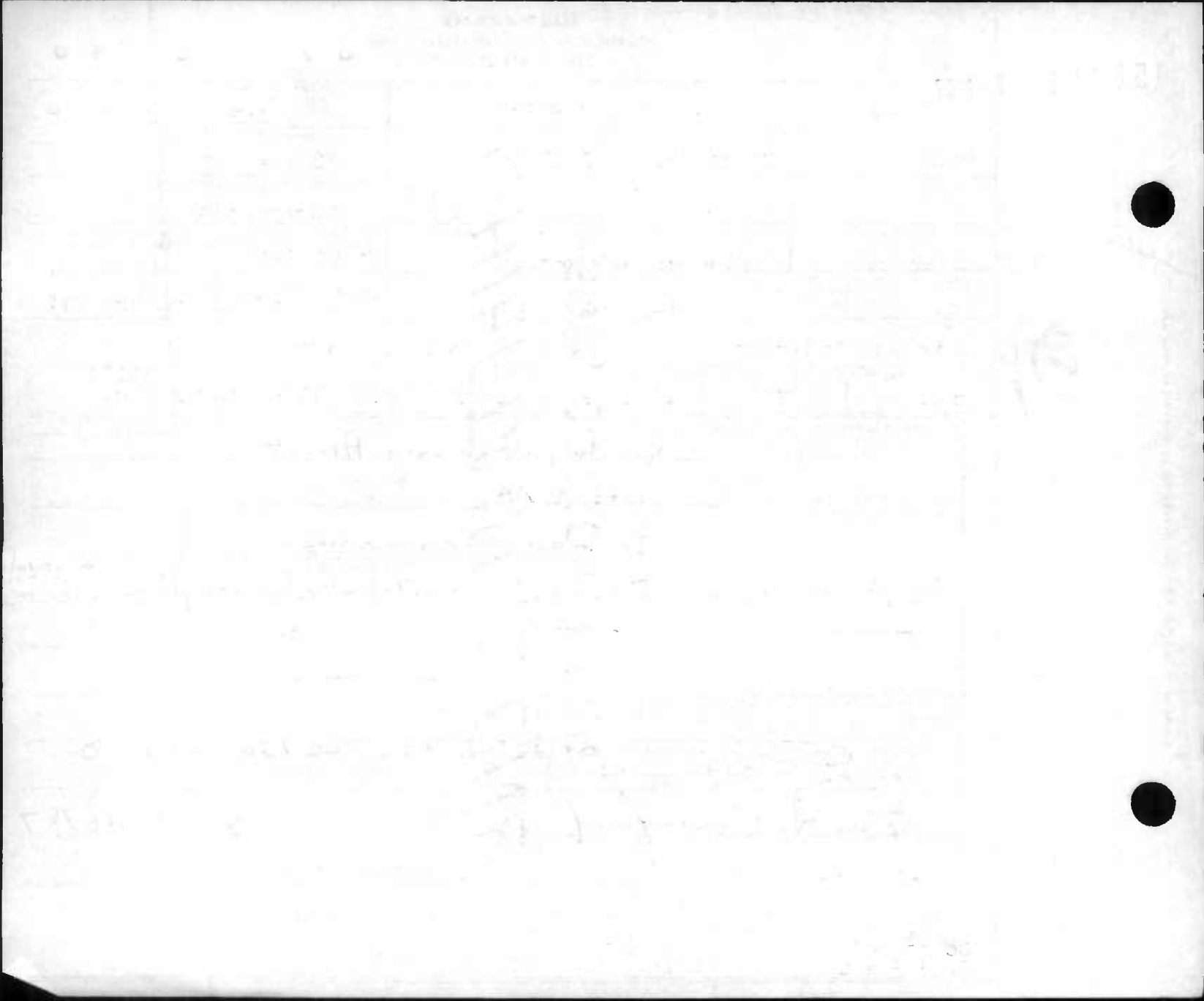
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13246

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl O. Anderson		2a. DATE OF DEATH MONTH DAY YEAR 05 26 87		2b. HOUR 9:15 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5-27-1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 72 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock Co.	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linneal Sodergren		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes.		16b. SOCIAL SECURITY NO. 212-09-2026	
17. INFORMANT ADDRESS Evelyn Reid 3905 Kenyon Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trilobar Pneumonia.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bilateral Carotid Arterial Disease</u> <u>Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>05/22</u> , 19 <u>87</u> , to <u>05/26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Steven J. Crawford</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/26/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven J. Crawford		22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-29-87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR Schmunek Funeral Home Inc. 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia...</u>	

BP



053878 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 13247	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERIC Paterson ANDERSON						2a. DATE OF DEATH MONTH DAY YEAR 05 16 87		2b. HOUR 1245 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 06 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1700 Meridone Drive 21239			
14. FATHER'S NAME FIRST MIDDLE LAST John P. Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-01-2270		17. INFORMANT ADDRESS Mrs. R. Camilla Anderson Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Probable Malignancy DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sepsis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 05/04 , 19 87 , to 05/16 , 19 87 , that (1) (we) last saw the deceased alive on 05/16 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) did not view the body after death.											
22b. SIGNATURE B. Schamberger, MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 05/16/87.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beatrice Schamberger MD		22e. ADDRESS 301 St. Paul - Baltimore MD 21202									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE <i>Lia D. Ruck</i>			

MEDICAL CERTIFICATION

1940

1940-10-10

1940-10-10
1940-10-10
1940-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 of this certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

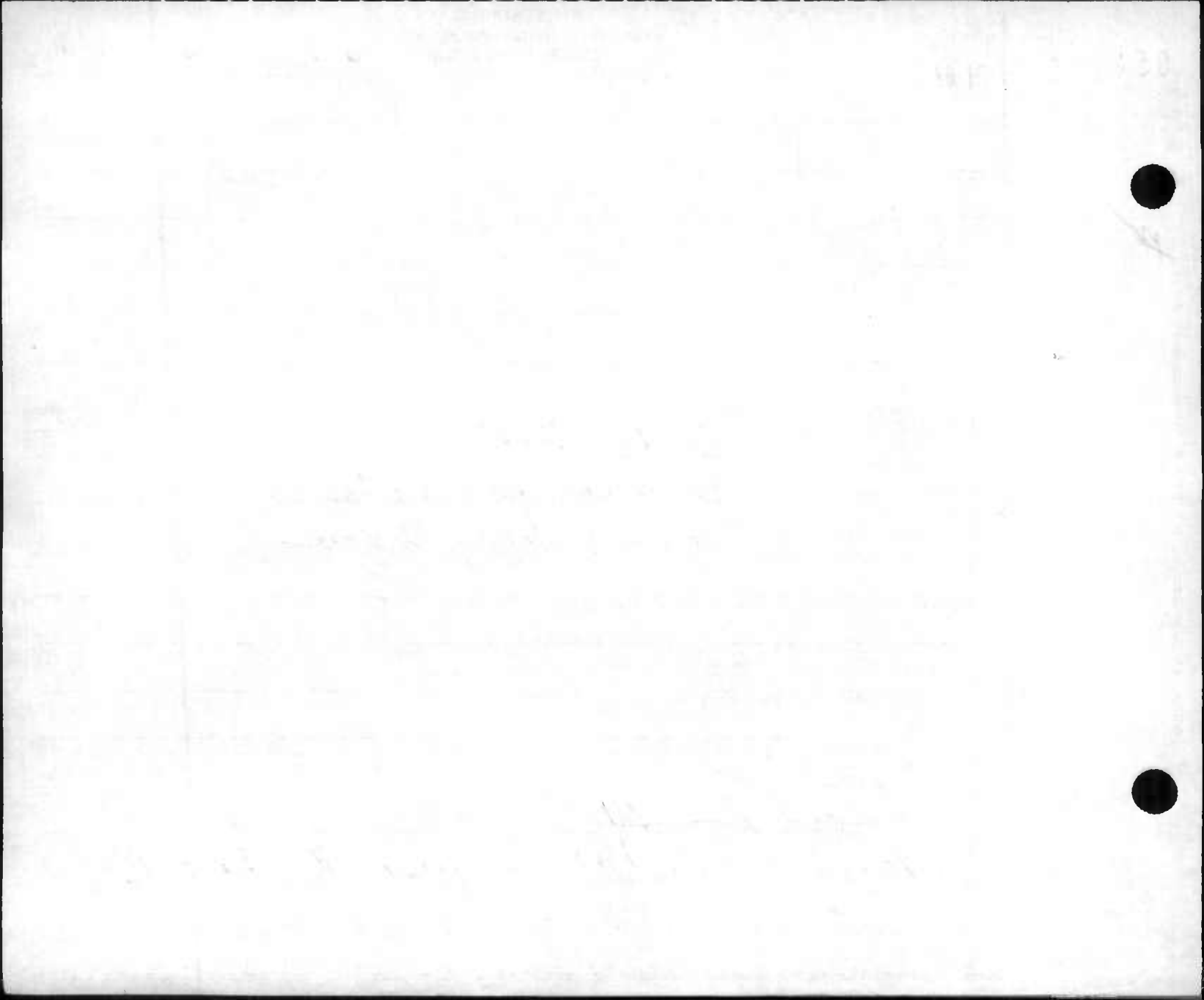
BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 4 8
REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST George	MIDDLE L.	LAST Anderson	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 626 N. Arlington Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Howard H. Hahn Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 626 N. Arlington Ave. 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Norman G. Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Simms		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 212-18-9834		17. INFORMANT Louise Redfern		ADDRESS 6120 Macbeth Dr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Congestive Heart Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1: OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Young S Kim MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Young S Kim MD		22e. ADDRESS 229 Greene St Balt MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/19/87		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H West 4300 Wabash Ave.				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendley				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

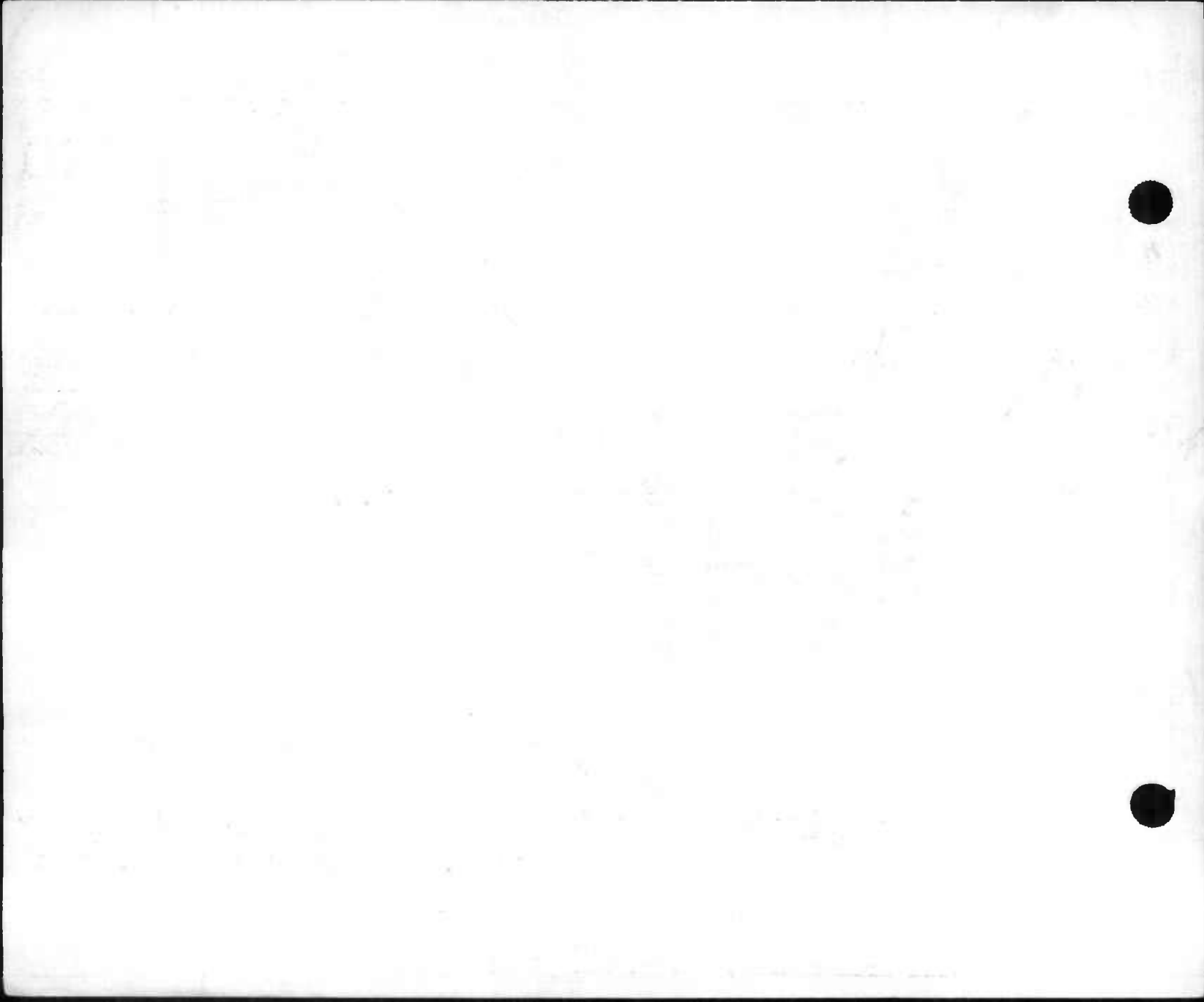
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST SAVERIO		MIDDLE ANOIA		LAST ANOIA		2a. DATE OF DEATH MONTH DAY YEAR MAY 28, 1987		2b. HOUR 4:10P ^M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 8 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? ITALY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL CORP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION WORKER		12b. KIND OF BUSINESS OR INDUSTRY BLDG CO.			
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 29 N. LUZERNE AVE. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST ANTONIO ANOIA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIANGELA COMMODARI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-36-4462		17. INFORMANT ADDRESS GIUSEPPE ANOIA (SON) SAME ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE STROKE DUE TO, OR AS A CONSEQUENCE OF (b) HIGH BLOOD PRESSURE/D.M. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from MAY 8, 19 87, to MAY 28, 19 87 that (I) (we) last saw the deceased alive on MAY 28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. P. Noyemi M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/28/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/1/87		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.					
24. FUNERAL DIRECTOR SCHLUMNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR JUN 3 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



054698 MAY 1987

Item 2a Film G628 6/30/87 jab

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13250

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD Florian APPLEBY, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 05 26 87			2b. HOUR 1 45 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 01 06	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. WKA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. CITY MD.					
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO. GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Model Maker			12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN BALTO		
14. FATHER'S NAME FIRST MIDDLE LAST William Appleby			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Killen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215 017877			17. INFORMANT ADDRESS Mrs. Agnes C. Appleby Same as 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANXIOUS ENOPHAKOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 DAYS
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PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>S/P CPR w/ Ventricular F.B.</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 19 <u>87</u> , to <u>May 26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Paul T. Barbera Jr.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5.26.87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL T. BARBERA JR.		22e. ADDRESS 3001 S. Hanover St., Balto., Md. 21225	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/29/87	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., A.A. Co., Md.
24. FUNERAL DIRECTOR NAME 237 E. Patapsco Ave., McCully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR MAY 27 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

52

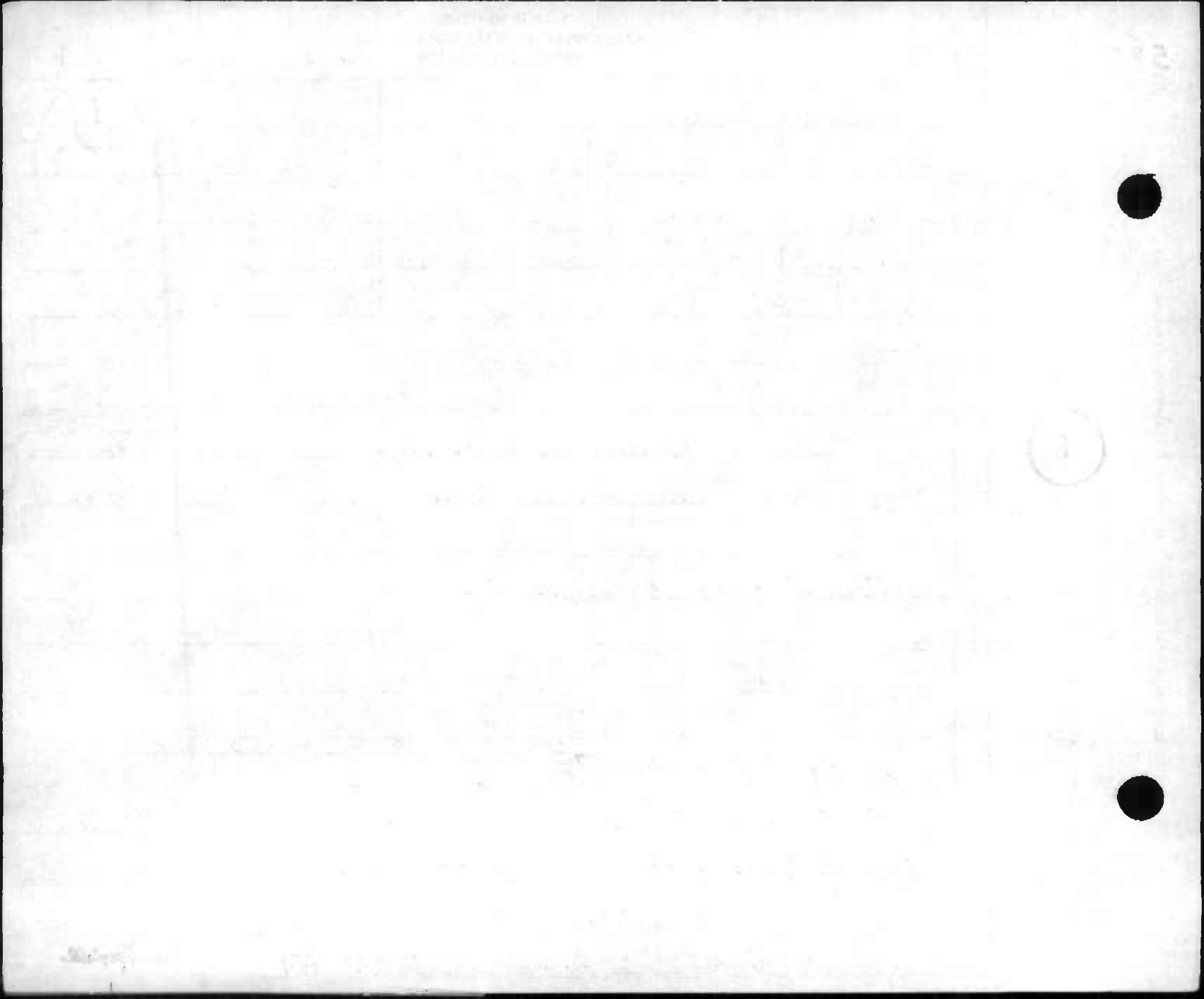
BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13251
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edwin Smallwood Archer			2a. DATE OF DEATH MONTH DAY YEAR 5 2 87			2b. HOUR 1:50 P M	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 1 8 96		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Hamilton Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Motors		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Archer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Clayton		13e. STREET ADDRESS 1807 Swansea Rd. 21239			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-01-5397		17. INFORMANT ADDRESS Esther L. Archer 1807 Swansea Rd. 21239			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Arteriosclerotic Cerebrovascular Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 13 1987</u> to <u>MAY 2 1987</u> , that (I) (we) last saw the deceased alive on <u>APRIL 13 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Walter R. Welzant, MD.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>MAY 4 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER WELZANT</u>				22e. ADDRESS <u>6100 YORK RD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-5-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Christian Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc. 6415 Belair Rd. 21206				25a. DATE REC'D. BY REGISTRAR MAY 4 - 1987		25b. REGISTRAR'S SIGNATURE <u>Davidson-Rodell</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

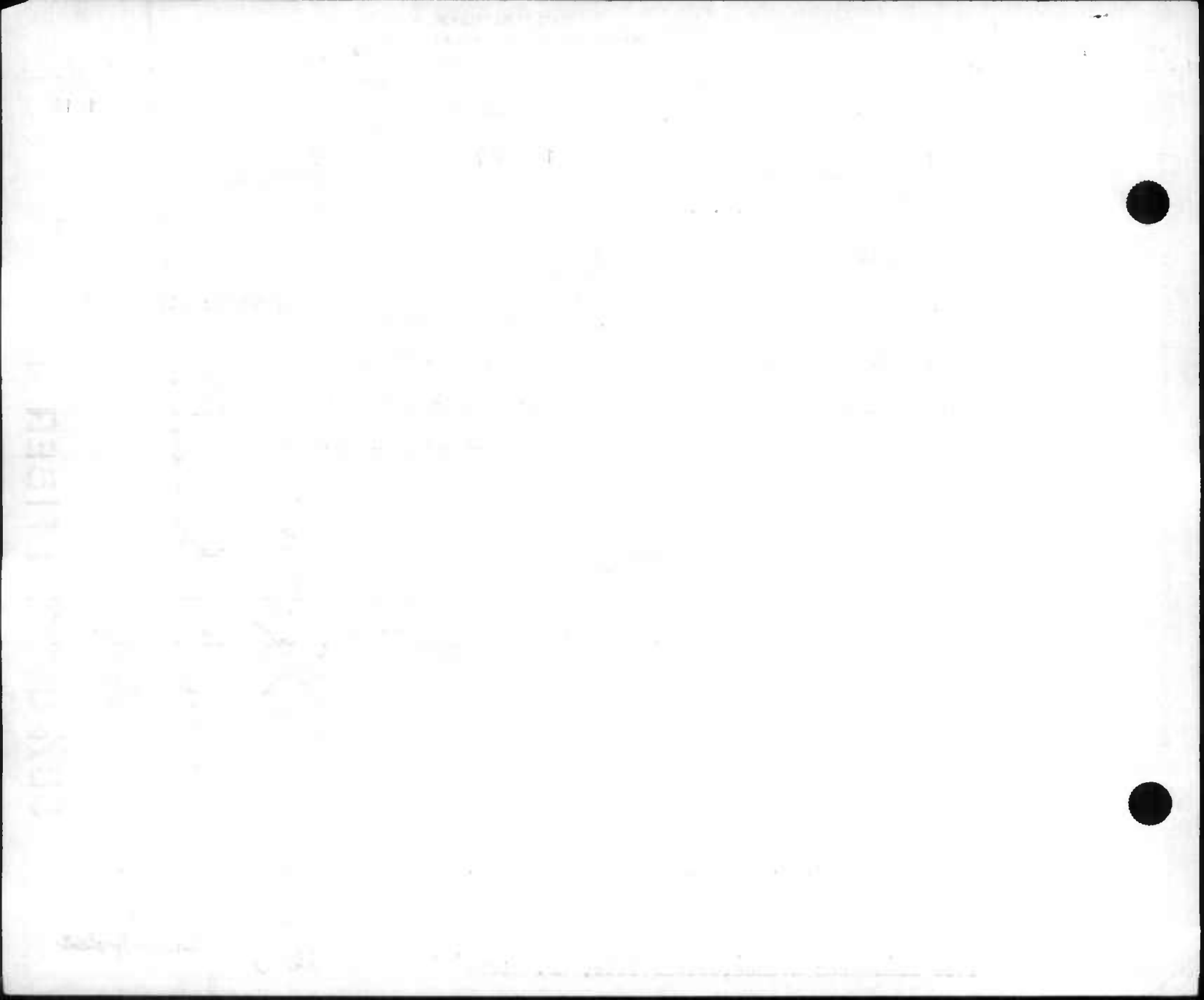
IMPORTANT: If item 21 is marked item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 3 2 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSE R. ARIZAGA			2a. DATE OF DEATH MONTH DAY YEAR 5 7 87		2b. HOUR 1810 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11/06/27	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PERU	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Psychiatrist	12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2137 Cedar Circle Drive 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Genaro Arizaga		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alejandrina La Torre			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. 219-38-5366	17. INFORMANT ADDRESS Constance Arizaga Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Probable Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Coronary Artery Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION 5/7/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen J. Planthall		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Planthall		22e. ADDRESS St. Agnes Hospital, Baltimore, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/11/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR Leory M. & Russell C. Witzke			25a. DATE REC'D. BY REGISTRAR MAY 8 1987		
1630 Edmondson Avenue, Catonsville, MD. 21228			25b. REGISTRAR'S SIGNATURE John Davidson-Robert		



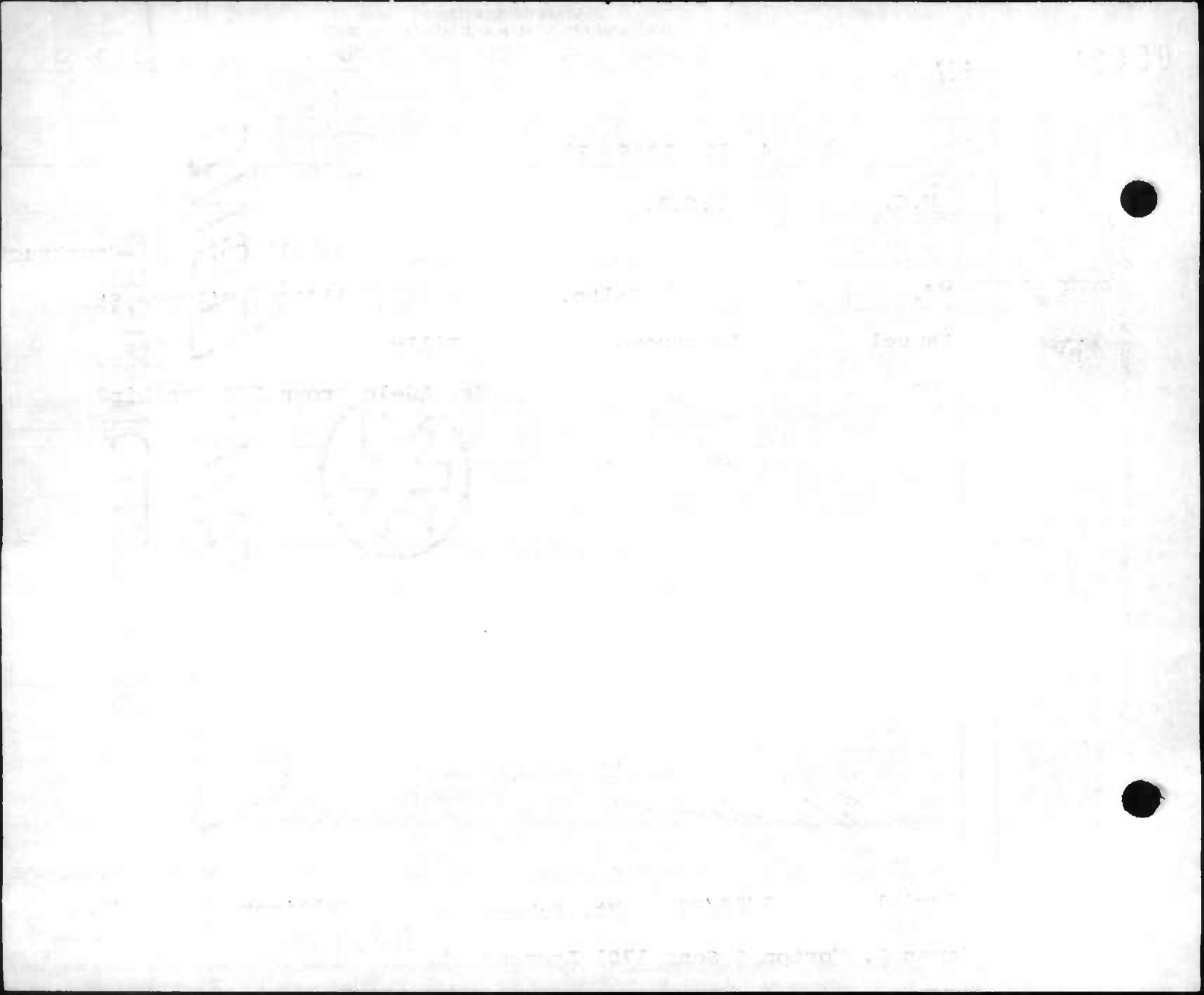
Item 18c per phone M.E.'s office
 FOR
 1- STATE 7/1/87 dad
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13253

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
Ernest						Armstrong		2a. DATE KNOWN OF DEATH		5		20		1987		AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	B	4 17 1955		32 YRS.						5		20		1987		2:31 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
N.C.		U.S.A.		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital		Asphalt Co.		Construct											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1103 N. Gilmore St.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Samuel		Lilly															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no				Ms. Adele Brown		702 Reedbird											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Gastrointestinal hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
						DUE TO, OR AS A CONSEQUENCE OF											
						(b) Acute gastric ulcer											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c) Alcoholism											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		Hypertensive Cardiovascular Disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		5-20-87							
EXAMINER'S NAME (TYPE OR PRINT)		William M. Zane, M.D.		ADDRESS		111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		5/23/87		Mt. Auburn		Baltimore						Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
James A. Morton & Sons		1701 Laurens St.		MAY 21 1987		Julia Davidson-Randall											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAYS ARE NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-33-RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13254

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAGGIE VIRGINIA ARRINGTON			2a. DATE OF DEATH MONTH DAY YEAR 5 24 87		2b. HOUR 0500 PM
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 15 24		6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Virginia Donuts-Owner		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2507 Albion Ave. 21214	
14. FATHER'S NAME FIRST MIDDLE LAST James P. Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Mc Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-24-1052		17. INFORMANT ADDRESS William Arrington 2507 Albion Ave. 21214	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Atherosclerotic Cardiovascular DZ</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> 19 <u>87</u> , to <u>5/24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>S. O. IEROTOLA</u>		DEGREE MD		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. O. IEROTOLA MD		22e. ADDRESS @201 UNIVERSITY PARKWAY			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 5/28/87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Va. Owings Mills, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE <u>Julia D. [Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Paper 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50842



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13255

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Inez LAST ARVIN			2a. DATE OF DEATH MONTH MAY DAY 30 YEAR 1987		2b. HOUR 1:20 PM						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 1 DAY 22 YEAR 33		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2721 E. Biddle St. 21213		
14. FATHER'S NAME FIRST Samuel MIDDLE Walton LAST			15. MOTHER'S MAIDEN NAME FIRST Rena MIDDLE Watson LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-38-9088			17. INFORMANT ADDRESS Doris B. Craig Rt. 2 Box 362E Victoria, VA 23974					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholic Hepatitis, Cachexia.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2 weeks.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Squamous Cell Carcinoma of tongue.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 14</u> 19 <u>87</u> to <u>May 30</u> 19 <u>87</u> , that (I) <u>did</u> did not <u>view the body after death.</u> saw the deceased alive on <u>May 30</u> 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> did not view the body after death.											
22b. SIGNATURE <u>Raymond T. Cunniff</u>			DEGREE MD - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/30/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Raymond T. Cunniff</u>			22e. ADDRESS <u>600 N. Wolfe St. BALTO, MD, 21205</u> <u>Johns Hopkins Hospital</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/3/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME <u>C. March F/H</u> ADDRESS <u>1101 E. North Ave.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 2 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>			

BP _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These provisions apply to deaths occurring on or after 1-1-87. Deaths occurring prior to 1-1-87 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the deceased has been properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 13256

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD ASH			2a. DATE OF DEATH MONTH DAY YEAR 5 9 87		2b. HOUR 2:00	
3. SEX MALE	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8 8 03		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Headwaiter.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Ash		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-01-9586		17. INFORMANT ADDRESS Mrs. Dorothy Ash - Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) COPD						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: RUNTUNE 870 MARCH						
19a. DATE OF OPERATION 5-2-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED REPAIR OF ABD. WOUND DEFENSE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/23 19 87, to 5/2 19 87, that (I) (we) last saw the deceased alive on 5/2 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Ambacher Worneth		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHER WORNETH		22e. ADDRESS NORTH CHARLES HOSPITAL, BALTO MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-11-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Radabaugh

BP

15.5.20

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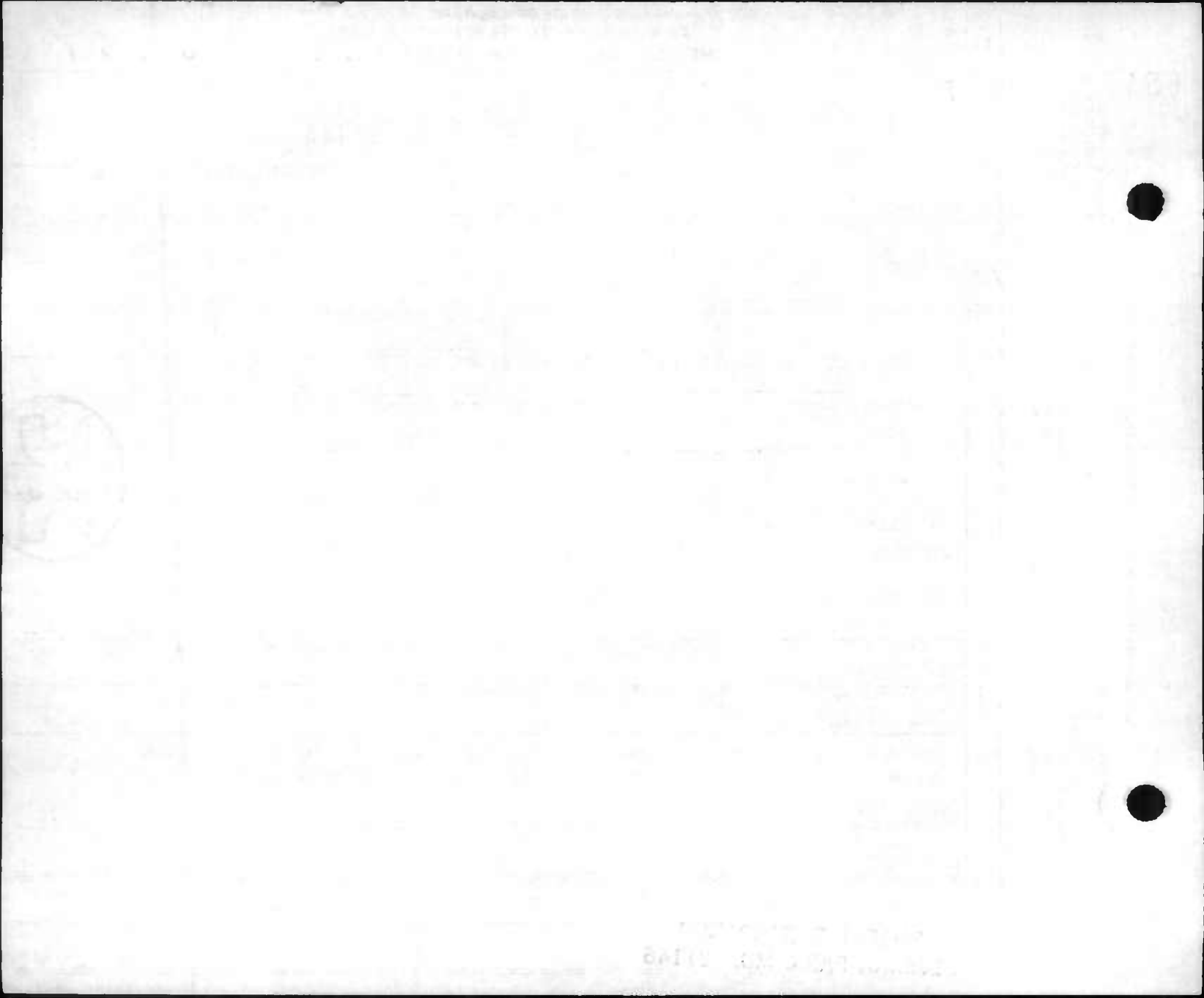
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054799 MAY 25 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13257			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank R. Ashby										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 20 19 87		2b. HOUR 4PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 - 9 - 21		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 20 19 87		2d. HOUR 4PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 412 Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown			12b. KIND OF BUSINESS OR INDUSTRY Unknown			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 Park Avenue / 21201				
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Ashby					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 235-28-3223			17. INFORMANT ADDRESS Marcella Jones 320 Gordon Avenue Severna Park, MD 21146							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive & arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>William M. Zane</u>				TITLE (SPECIFY) Assistant M.D.				MEDICAL EXAMINER		DATE SIGNED 5/21/87			
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.				ADDRESS 111 Penn St.				Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5-23-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Westview, Baltimore, MD					
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO						25a. DATE REC'D. BY REGISTRAR MAY 27 1987			25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>				
SEVERNA PARK, MD. 21146													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit, pages 1 and 2, and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, the attending physician must be notified and a police report filed.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADAM ELLIOTT ATHANAS			2a. DATE OF DEATH MONTH DAY YEAR MAY 16, 1987		2b. HOUR 8:41P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 7, 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 9	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) =====		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Carroll Co.	13c. CITY OR TOWN Eldersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Larry D. Athanas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara A. Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ===		17. INFORMANT ADDRESS Larry Athanas (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). PROLONGED METABOLIC/RESPIRATORY ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF (c). THANATOPHORIC DWARFISM					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 03 MINS 3 DAYS 9 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/7 , 19 87 , to 5/16 , 19 87 , that (I) (we) lost saw the deceased alive on 5/16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard Orel		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD OREL		22e. ADDRESS JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALT, MD 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/19/87	23c. NAME OF CEMETERY OR CREMATORY Crestlawn Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville, Howard Co., MD
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hg., Baltimore, MD			25a. DATE REC'D. BY REGISTRAR MAY 19 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson		

(21225)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 13259

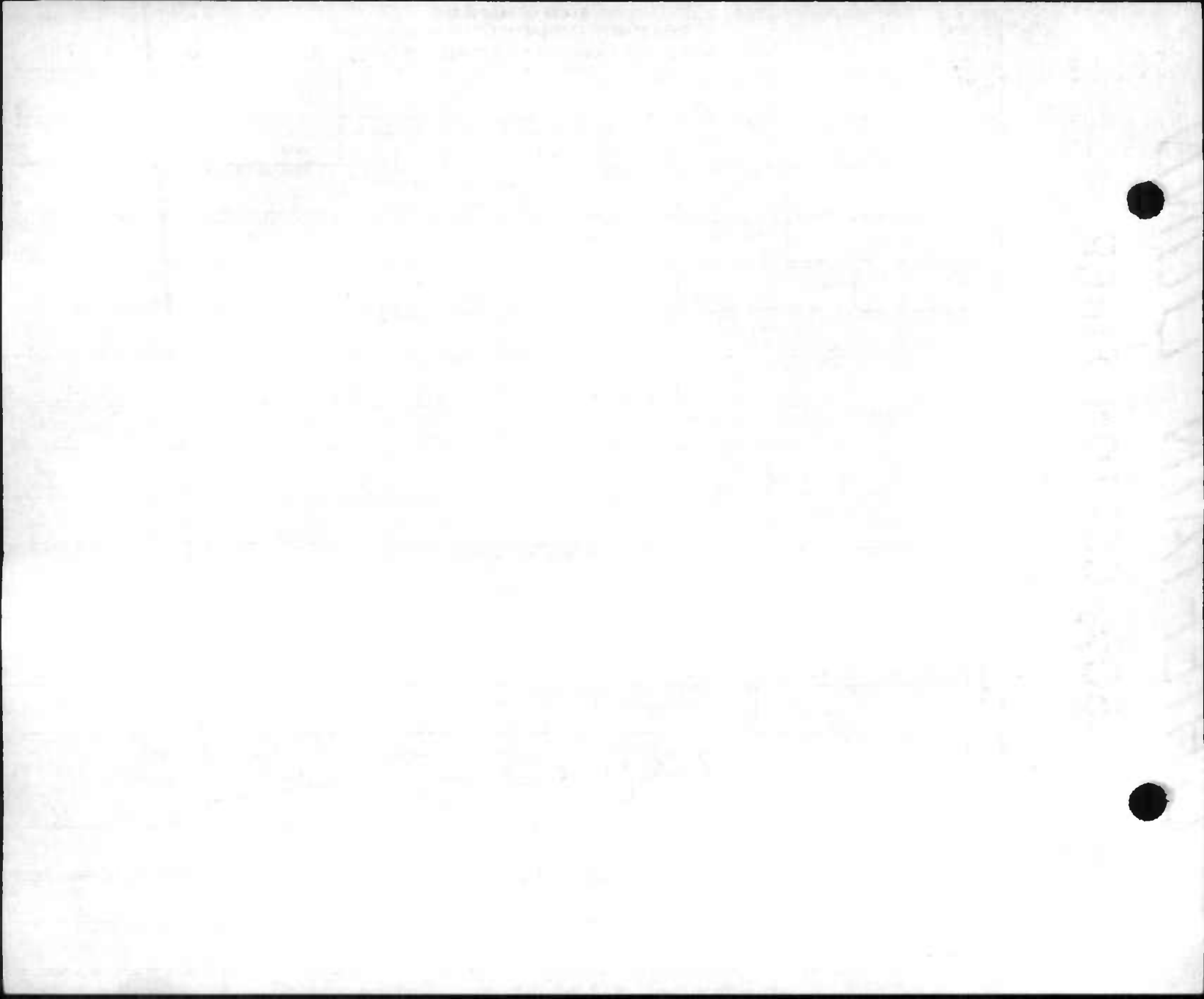
1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Dorothy L. Atkins		female		black	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 24 HRS.	
3 22 1913		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md		U S A		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		1609 Retreat St.		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md		Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS	
George Lee		Mary Alston		1609 Retreat Street 21217	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-10-0165		Alston Atkins 6759 Ransone Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant MEDICAL EXAMINER		5/25/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dennis F. Smyth, M.D.		111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/1/87		Arbutus Memorial Park	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H West 4300 Wabash Avenue		JUN 1 1987		Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WP-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
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DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13260
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James E Atkinson				2a. DATE OF DEATH MONTH DAY YEAR 5 13 87 2b. HOUR 5:40 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 16 - 25		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE VA MED. CTR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY Own	
13a. STATE MD				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 2024 N. CHARLES ST. / 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Stephen F. Atkinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille C. Crowell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			
16b. SOCIAL SECURITY NO. 249-24-1936		17. INFORMANT Greenville S.D. 29601 Apt. B211 James E. Atkinson, Jr. 926 Cleveland St.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER - SQUAMOUS CELL</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>87</u> to <u>5/13/87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. HAN, MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. HAN				22e. ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/18/1987		23c. NAME OF CEMETERY OR CREMATORY Crownsville, V.A. Ct.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Maryland	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave.				25a. DATE REC'D. BY REGISTRAR MAY 18 1987			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713261

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALVINA M. AUER			2a. DATE OF DEATH MONTH DAY YEAR MAY 20 1987		2b. HOUR 9A. M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 1 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 535 N. KENWOOD AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PACKER	12b. KIND OF BUSINESS OR INDUSTRY BAKERY	
13a. STATE MD.	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 535 N. KENWOOD AVE. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN AUER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESIA HAMMEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-01-9609		17. INFORMANT ADDRESS ELSIE AUER (SISTER-IN-LAW) same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Anterior Subarterial Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/3</i> 19 <i>85</i> , to <i>5/20</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>5/2</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Joseph R. Liberto</i>		DEGREE MD		22c. DATE SIGNED <i>5/22/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSEPH LIBERTO		22e. ADDRESS 3508 BANK ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/23/87	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE <i>John Deacon-Randall</i>	

BP

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 2 6 2

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert W. Aulton			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/ 4/ 19 87			2b. HOUR M 1:45 a M
3 SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 5 47	6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/ 4/ 19 87	7d. HOUR a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD
10. CITY OR TOWN OF DEATH Baltiomre		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) URBAN SERVICES		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1902 Cedric Rd. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Aulton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Mathews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214440665		17. INFORMANT ADDRESS Hazel Aulton 1902 Cedric Rd. 21216		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism and Hypertrophic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER DATE SIGNED 5/4/87		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus		
23d. LOCATION CITY OR TOWN Arbutus Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 7 1987		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))



53944 MAY 2 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 87 13263				
1. DECEASED NAME (TYPE OR PRINT) Barbara E. Austin					2a. DATE OF DEATH MONTH 5 DAY 17 YEAR 87				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 11 DAY 23 YEAR 33		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4938 Edgemere Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4938 Edgemere Ave. 21215	
14. FATHER'S NAME FIRST Thompson MIDDLE LAST 					15. MOTHER'S MAIDEN NAME FIRST Thompson MIDDLE LAST 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. Unkn		17. INFORMANT Gary Austin		ADDRESS 102 Mt. Holly St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) ADENOCARCINOMA - METASTATIC FROM BOWEL DUE TO, OR AS A CONSEQUENCE OF (c) IMMUNOCOMPROMISED SYSTEM									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CACEXIA SECONDARY TO PARTIAL BOWEL OBSTRUCTION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGH E. MIGHTY M.D.					22e. ADDRESS 3319 W. BELVEDERE AVE. BALT. MD. 21215				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Anne Arundel Co., Md. COUNTY STATE 			
24. FUNERAL DIRECTOR NAME Wm C March F.H. West ADDRESS 4300 Wabash Ave.					25a. DATE REC'D BY REGISTRAR MAY 19 1987 25b. REGISTRAR'S SIGNATURE 				



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055015 JUN

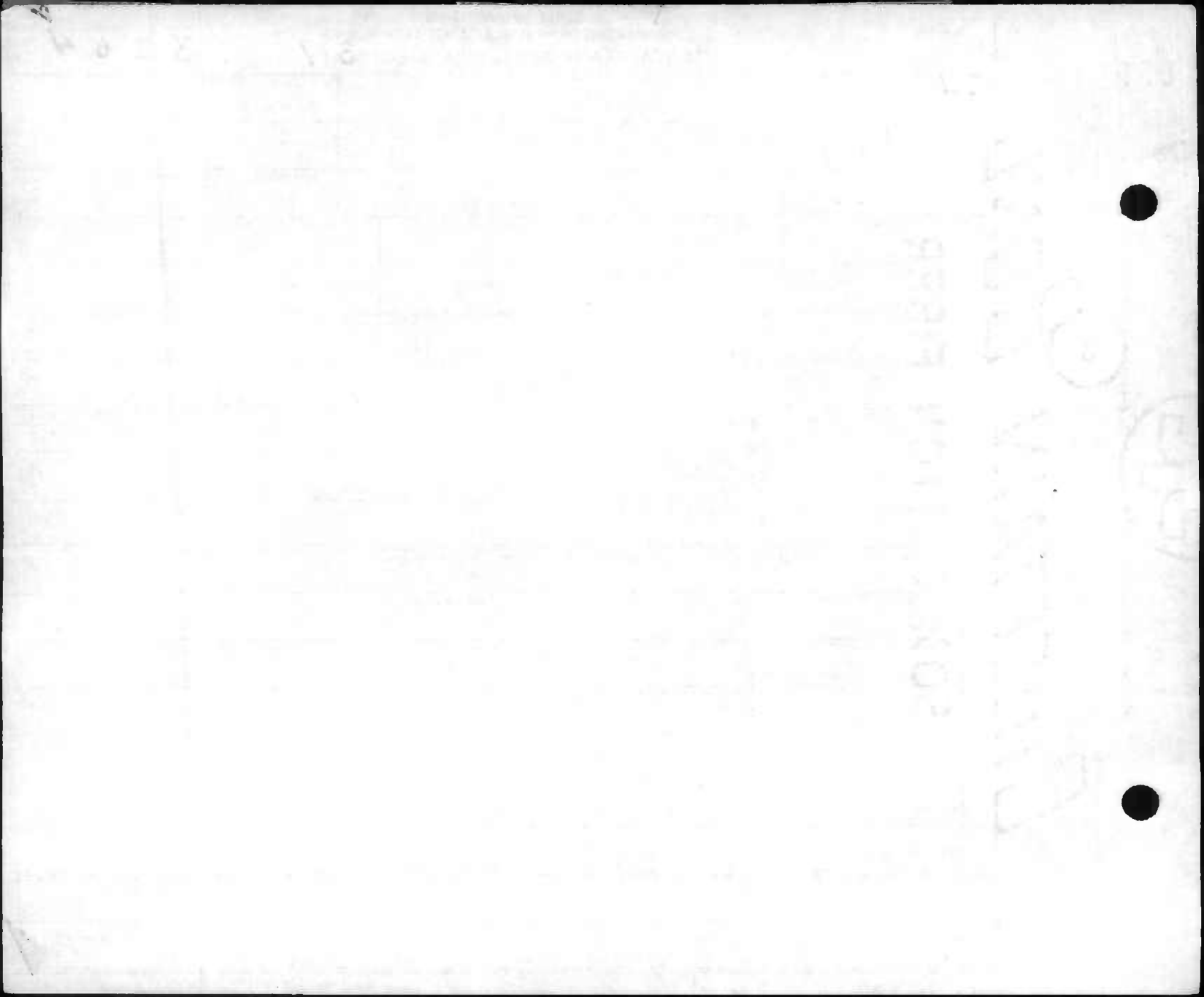
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18b. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH 10:00 PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items, 18a, 18b, & 22a, G-22a, by STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE Med. Ex., 7/15/87, REGISTRAR Gbj, MEDICAL EXAMINER'S CERTIFICATE OF DEATH, REG. NO. 13264

1. DECEASED NAME (TYPE OR PRINT) Dozie M. Bailey			2a. DATE KNOWN OF DEATH ESTIMATED 5/ 24/ 19 87		2b. HOUR 4:55 P.M.
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 4 27 1933	6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5221 St. Charles Ave.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 5221 St Charles Avenue 21215	
13b. COUNTY Md		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jim R. Newsome		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Bryant		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 196-28-1001		17. INFORMANT Warren Bailey		ADDRESS 318 N. Denison Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) Vascular Malformations DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dennis F. Smyth		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER DATE SIGNED 5/25/87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/30/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY Md		STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West		ADDRESS 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUN 1 1987	
25b. REGISTRAR'S SIGNATURE Julia Dandridge-Randall					

07/84
25MDHMH - 17
(VR A15 ME (5))



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **13265**

1- STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST
RUSSELL L. BAILEY

2a. DATE KNOWN OF DEATH MONTH DAY YEAR
☒ 5 29 1987

2b. HOUR M
11:29 AM

3. SEX Male **4. RACE** Black

5. DATE OF BIRTH MONTH DAY YEAR
11/25/25

6. AGE (IN YEARS) 61 YRS.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
6 3 1987

7d. HOUR M
11:29 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md.

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1222 Druid Hill Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Md. **13b. COUNTY** **13c. CITY OR TOWN** Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐ **13e. STREET ADDRESS**
1222 Druid Hill Ave. 21217

14. FATHER'S NAME FIRST MIDDLE LAST
Russell L. Bailey Sr.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Estelle Segmore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
220-16-7697

17. INFORMANT ADDRESS
Kirk Bailey 500 Glenn Allen Dr. 21229

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis of the liver

DU TO, OR AS A CONSEQUENCE OF

(b) Chronic alcoholism

DU TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION **19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?** **20. AUTOPSY?** Head & Abd. YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Ann M. Dixon* **TITLE (SPECIFY)** Deputy Chief **DATE SIGNED** 6-3-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. **ADDRESS** 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial **23b. DATE** 6/9/87 **23c. NAME OF CEMETERY OR CREMATORY** Bethel Cemetery **23d. LOCATION** CITY OR TOWN COUNTY STATE
Cambridge, Maryland

24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Place

25. DATE RECEIVED BY REGISTRAR JUN 10 1987 **26. REGISTRAR'S SIGNATURE** *Julia Bender-Rubio*

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(25.12)

MIN 10 100

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 / 1 3 2 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon Baldwin, Sr.			2a. DATE OF DEATH MONTH DAY YEAR May 30, 1987		2b. HOUR 4:05 A.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 6, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3952 Hickory Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintainance		12b. KIND OF BUSINESS OR INDUSTRY Noxell Corp.			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3952 Hickory Avenue 21211		
14. FATHER'S NAME FIRST MIDDLE LAST Leonard F. Baldwin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Cross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 14 6201		17. INFORMANT Virginia Baldwin			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kidney Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard L. Diamond</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-1-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Diamond				22e. ADDRESS 3952 Chestnut Avenue Baltimore, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/02/1987		23c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden)		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland				
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home				ADDRESS Baltimore, MD 21211		25a. DATE REC'D. BY REGISTRAR JUN 3 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP _____

1900 OCT 24 1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

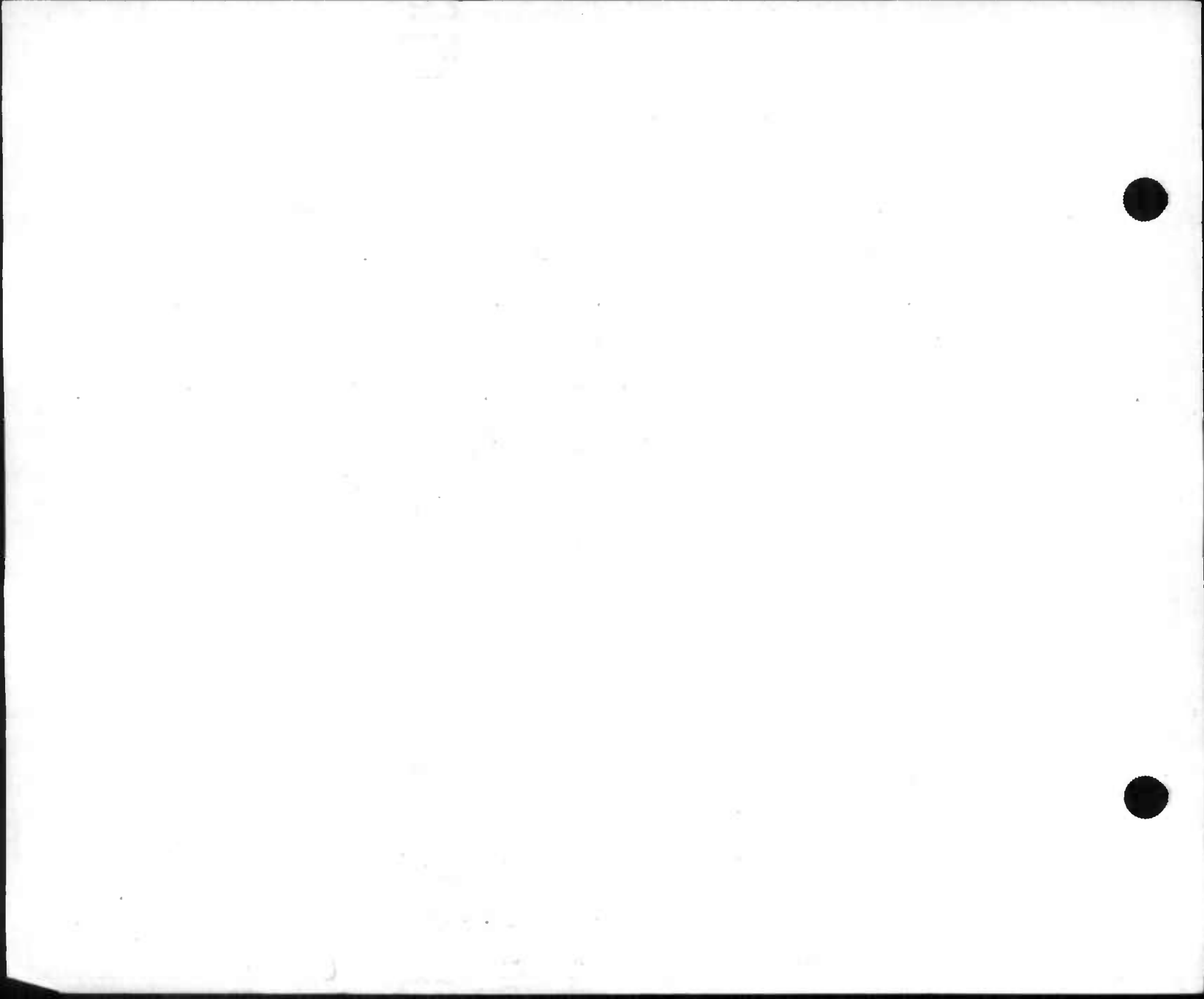
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 6 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Charles David Osborne Ballard		5 31 87 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		MONTH DAY YEAR 1 4 12		75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		2825 Baker Street		Mail Handler		Post Office	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Thomas Ballard		FIRST MIDDLE LAST Rosa Cole		Yes WWII		215-07-0775	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Martha Ballard		2825 Baker St.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
M. Ali Khan							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
M. ALIKHAN, MD.		Greensboro Med Ctr.		Burial		6/5/87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Arbutus Mem. Park		Arbutus Md.		Chatman-Harris		JUN 8 1987	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS		25d. DATE REC'D. BY REGISTRAR		25e. REGISTRAR'S SIGNATURE	
Julia Gordon-Randall		1701 McCulloh Street		JUN 8 1987		Julia Gordon-Randall	

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Kenneth L. BANAHAH				5-14-87		1830 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR 7 15 25		61 YRS.		IF UNDER 24 HRS.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U. S. A.				Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto.		St. Agnes Hospital		Retired Painter					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Christ Church Harbor Apartments-Balto., 600 S. Light St. Md. #21230	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Leo		Marie		Yes		219-16-8794		Mrs. Doris C. Bartels #21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Acute Myocardial Infarction						3 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from		19 87		to 5/14 19 87		that (I) (we) last saw the deceased alive on		19 87	
		5/14		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Paul Grimes, MD						5/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Paul Grimes, MD		St. Agnes Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		May 18, 1987		Md. Veterans Cemetery		Crownsville		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
G. Tramen Schwab		MAY 28 1987		Julia Gordon Radabaugh					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABLE C. BARNES		2a. DATE OF DEATH MONTH DAY YEAR 5/28/87		2b. HOUR 8:40 P.M.	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 2 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore city	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11. W 20th St Apt 14D 21218
14. FATHER'S NAME FIRST MIDDLE LAST Leviticus Wynn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wadie Youngblood		16. SOCIAL SECURITY NO. 212-10-1401	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT John G. Barnes		ADDRESS 4663 Delaware Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated intravascular clotting</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute RENAL Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/28/87 to 5/28/87, that (I) (we) last saw the deceased alive on 5/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marcos B. Galicia Jr., MD		DEGREE MD		22c. DATE SIGNED 5/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCO B. GALICIA, Jr., MD		22e. ADDRESS North Charles General Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue			
25a. DATE REC'D. BY REGISTRAR JUN 2 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE

W. L. G. 2 = 2000 11/10/99

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Baltimore City
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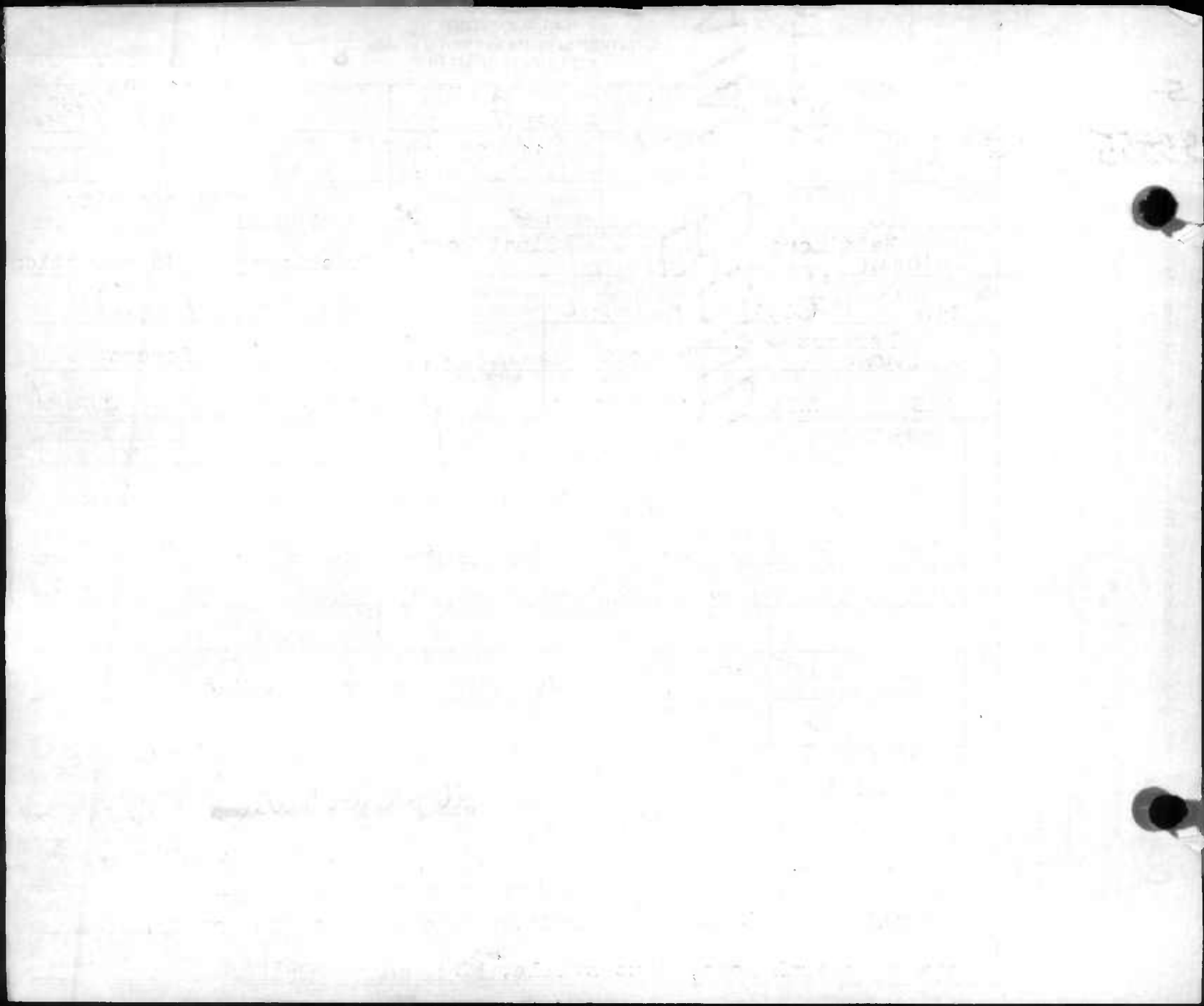
1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Your permit expires carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 1 3 2 7 0	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>WILLIAM</u> MIDDLE <u>H.</u> LAST <u>BARRETT</u>										2a. DATE OF DEATH MONTH <u>05</u> DAY <u>31</u> YEAR <u>87</u> HOUR <u>9</u> MIN <u>45</u> P.M.	
17. SEX <u>MALE</u>										18. RACE <u>CAUCASIAN</u>	
19. DATE OF BIRTH MONTH <u>11</u> DAY <u>20</u> YEAR <u>27</u>										6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS. IF UNDER 1 YEAR MONTHS <u>5</u> DAYS <u>31</u> IF UNDER 74 HRS. HOURS <u>9</u> MIN. <u>45</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>US</u>										7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hosp.</u>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Bricklayer.</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>											
13a. STATE <u>MD</u> 13b. COUNTY <u>BCITY</u> 13c. CITY OR TOWN <u>Baltimore</u>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>5610 Carroll Street</u> <u>21207</u>											
14. FATHER'S NAME FIRST <u>Herbert</u> MIDDLE <u>F.</u> LAST <u>Barrett</u>										15. MOTHER'S MAIDEN NAME FIRST <u>May</u> MIDDLE <u>L.</u> LAST <u>Lorenz</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u> (IF YES, GIVE WAR OR DATES) <u>WWII</u>										16b. SOCIAL SECURITY NO. <u>212-26-1941</u>	
17. INFORMANT ADDRESS <u>Gary D. Salomon, MD Sinai Hospital</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 8199										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <u>Aspiration (Recurrent) Pneumonia</u> 4 hours	
(c) <u>S/P Head Trauma with gastrostomy feedings</u> 3 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>S/P motor vehicle accident head trauma, flail chest (multiple rib fractures)</u>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY APPROX. MONTH <u>12</u> DAY <u>3</u> YEAR <u>84</u> <u>9:30 P.M.</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>Motor vehicle accident</u>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>street</u>	
21f. LOCATION STREET <u>not known</u> CITY OR TOWN <u>not known</u> COUNTY <u>not known</u> STATE <u>not known</u>											
22a. I certify that (1) this hospital attended the deceased from <u>12/3</u> , 19 <u>86</u> , to <u>5/31</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>5/31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. D. Salomon</u> DEGREE <u>MD</u>										22c. DATE SIGNED <u>5/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A.W. DAVIS</u>										22e. ADDRESS <u>Sinai Hosp of Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>										23b. DATE <u>06-03-87</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Crestlawn Cemetery</u>										23d. LOCATION CITY OR TOWN <u>Howard County, MD</u> COUNTY <u>Howard</u> STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home, Catonsville, MD</u> ADDRESS <u>MacNabb Funeral Home, Catonsville, MD</u>										25a. DATE REC'D. BY REGISTRAR <u>JUN 2 1987</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

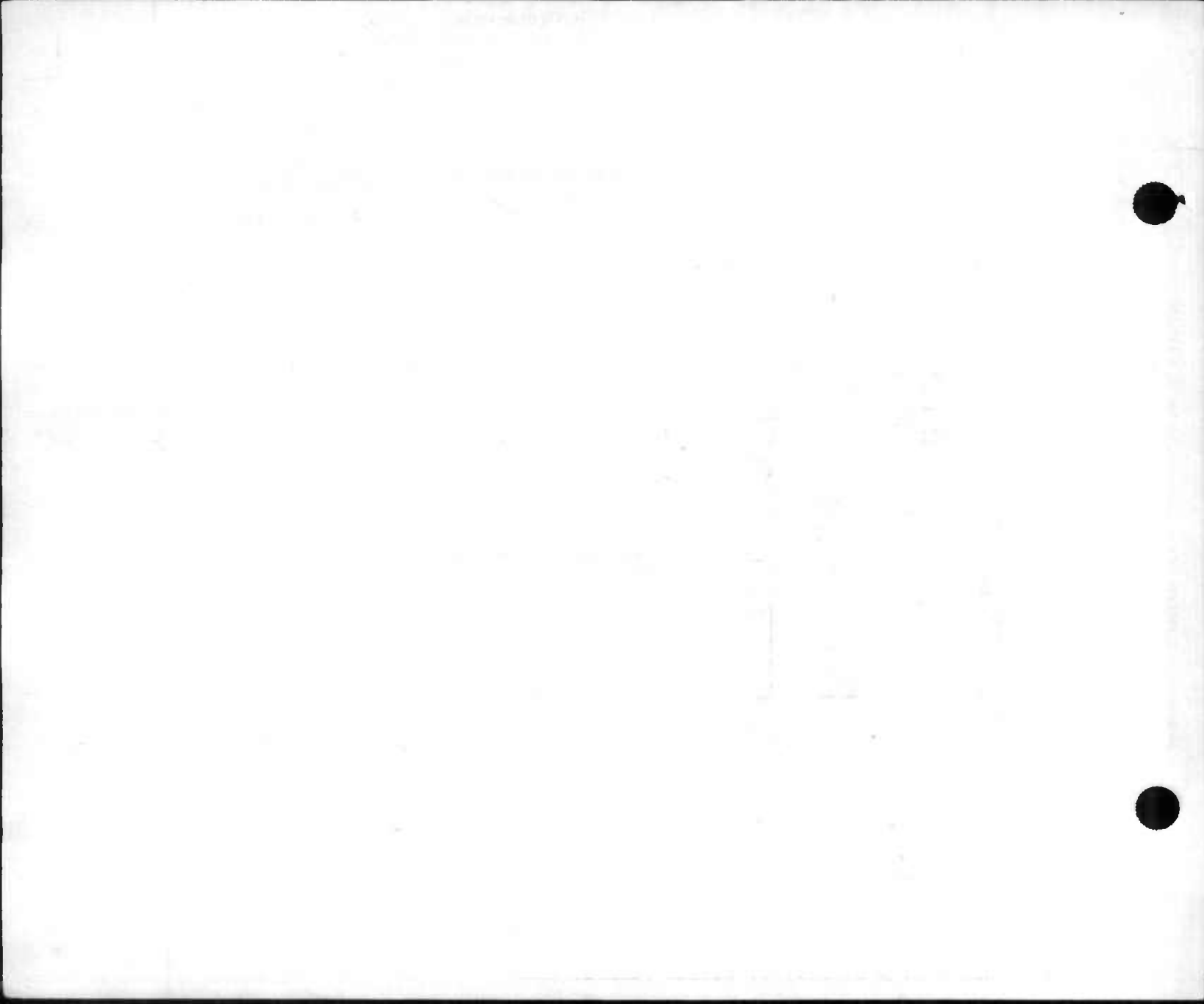
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13271

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
George Charles Bast Jr.				5/28/87		5 28 87		12:05 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	WHITE	1/17/18		69		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.			Baltimore City				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Balt. City	St Agnes Hospital	Attorney		Law					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Md. 21043 3137 The Oaks Rd. Ellicott City	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
George Charles Bast Sr.		Amelia M. Tiemann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
NO		386-18-2085		Karen Griffith		5048 Amesbury Dr. Columbia		Md. 21044	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>87</u> , to <u>5/28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Alm C Waterfield MD</u>						<u>5/28/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>Alm C Waterfield</u>		<u>St Agnes Hospital</u> <u>900 Caton Ave Balt 21229</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		6/1/87		Woodlawn Cemetery		Woodlawn		Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
1630 Edmondson Ave. Catonsville, Md. 21228									
Leroy M. & Russell C. Witzke Funeral Home									

JUN 2 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a cemetery filed in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

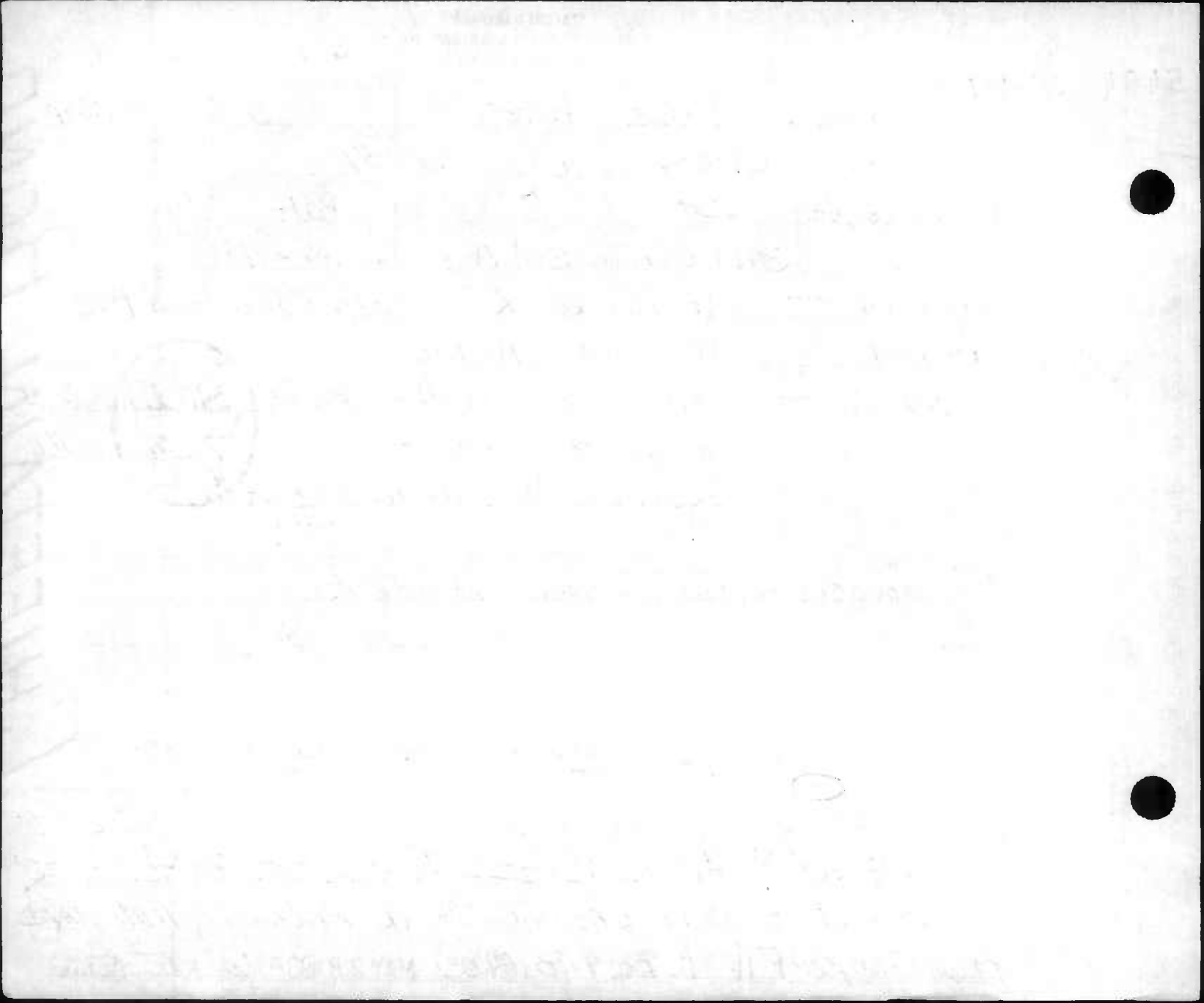
BP
DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie Gladys Bates			2a. DATE OF DEATH MONTH DAY YEAR 5 22 87			2b. HOUR 1:54pm			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 - 03 - 29		6. AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CAMBRIDGE, VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3414 EDMONDSON AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3414 Edmondson Ave 21229	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY MORGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE GEE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-28-5625A		17. INFORMANT ADDRESS Wilbert Bates 3414 Edmondson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Thoracic epidural + liver metastasis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from August 19 86 to May 19 87 , that (I) (we) lost saw the deceased alive May 15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joyce Y. Gross MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/26/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joyce Y Gross MD		22e. ADDRESS 22 S. Greene St. Balto. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-28-87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW MEMPH		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME BROWN-THOMPSON F.H.		ADDRESS P.O. Box 4433 (61223)		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Jackson-Pendleton			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be retained by the funeral director. Page 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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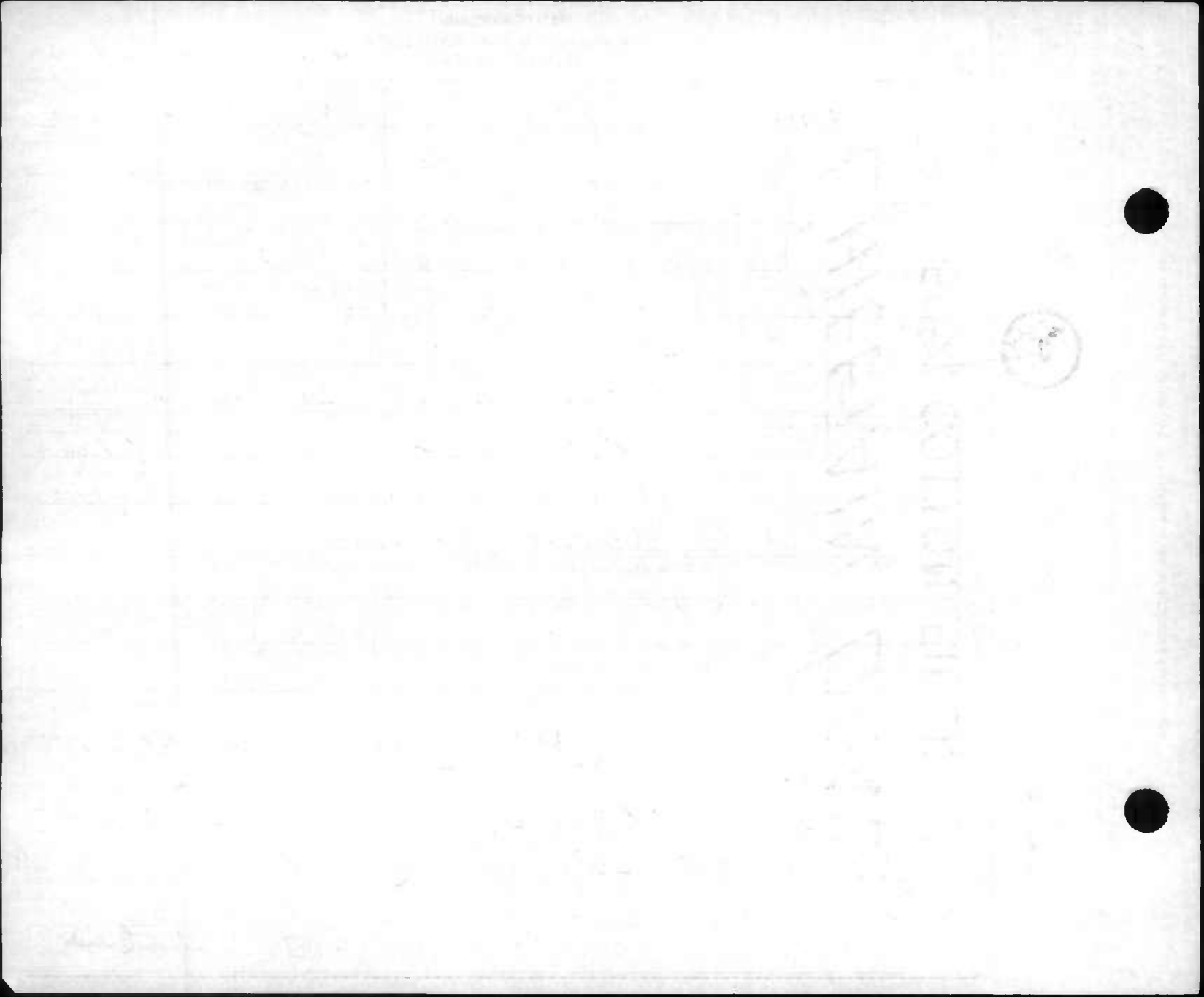
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13273

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vivian L. Baylor			2a. DATE OF DEATH MONTH DAY YEAR May 10, 1987		2b. HOUR 3:00 A.M.	
3. SEX female		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1945		
6. AGE (IN YEARS LAST BIRTHDAY) 42		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH City		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital & Medical Center		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		12b. KIND OF BUSINESS OR INDUSTRY HOSTESS		13b. COUNTY P.G.		
13c. CITY OR TOWN FOREST HEIGHTS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 119 MOHICAN DR. 20745		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD GUNN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BROOKS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
17. SOCIAL SECURITY NO. NOT STATED		18. INFORMANT ALFRED BAYLOR		19. ADDRESS FOREST HEIGHTS MD		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 8500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Dementia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heroin Overdose</u>		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 9 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		23d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Not		
23f. LOCATION STREET CITY OR TOWN COUNTY STATE 78 10 May 87		23g. I certify that (this hospital) attended the deceased from <u>Not</u> , 19 <u>78</u> , to <u>10 May</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>10 May</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.		23h. SIGNATURE Joseph W. Zebrowski DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23i. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph W. Zebrowski		23j. ADDRESS Deaton Hosp & Med Ctr. 611 S. Charles St		23k. DATE SIGNED 10. I. 87		
23l. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23m. DATE MAY 13 1987		23n. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK		
23o. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MARYLAND		23p. FUNERAL DIRECTOR WATSON F. H. INC 3435 WASH. D. C. 14th ST., N.W.		23q. DATE REC'D. BY REGISTRAR MAY 18 1987		
23r. REGISTRAR'S SIGNATURE Julia Gordon-Randall		23s. REGISTRAR'S NAME Julia Gordon-Randall		23t. REGISTRAR'S ADDRESS Julia Gordon-Randall		

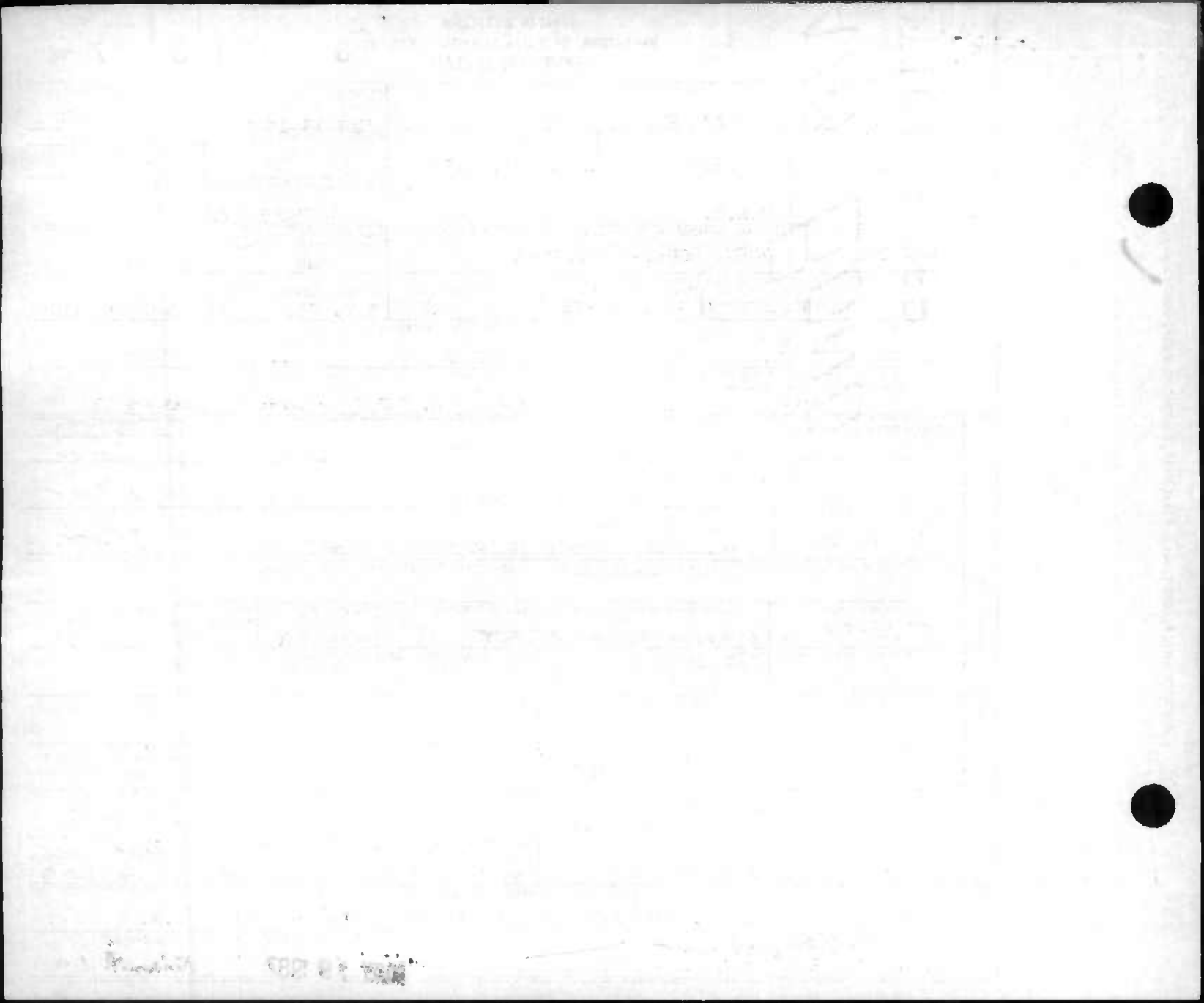


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 1 3 2 7 4	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MEGAN ELIZABETH BEALL						2a. DATE OF DEATH MONTH DAY YEAR MAY 16 1987				2b. HOUR 1:36P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 21, 1986		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 5 26		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN GLEN BURNIE						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 235D WOODHILL DRIVE 21061			
14. FATHER'S NAME FIRST MIDDLE LAST KENNETH L. BEALL						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERRI L. TEETS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS KENNETH L. BEALL (FATHER) SAME AS 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>METABOLIC ACIDOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LOW CARDIAC OUTPUT / HEART FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 1 DAY 3 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION 5-13-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UNIVENTRICULAR HEART				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> 19 <u>87</u> to <u>5-16</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-16</u> 19 <u>87</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard S. Stewart MD</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-16-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD S. STEWART MD						22e. ADDRESS 800 N. WOLFE ST. BALTO, MD. 21205 JOHNS HOPKINS HOSPITAL MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 19, 1987		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM'L PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.					
24. FUNERAL DIRECTOR NAME <u>ALB. V. JONES</u> ADDRESS SINGLETON FUNERAL HOME, GLEN BURNIE, MD.						25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE <u>Richard P. Jones</u>			



052624 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #111. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13275							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT Edward BECK, JR.										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 5-2-87 19		2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 20 33		6. AGE (IN YEARS) (LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 5-2-87 19		2d. HOUR 8AM M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3001 Janice Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic				12b. KIND OF BUSINESS OR INDUSTRY Mass Tran. Auth.					
13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3001 Janice Avenue 21230			
4. FATHER'S NAME FIRST MIDDLE LAST Albert E. Beck, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Ports											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. Korean 215-30-4861				17. INFORMANT Beverly A. Beck				ADDRESS 3001 Janice Ave. 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) bleeding peptic ulcer																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE John E. Smialek, M.D.				TITLE (SPECIFY) Chief				MEDICAL EXAMINER				DATE SIGNED 5-2-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/6/87				23c. NAME OF CEMETERY OR CREMATORY Loudon park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR MAY 4 1987				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

W. J. [Signature]

2025 COLLECTED

W. J. [Signature]

2025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death investigation is indicated.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13276

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ollie Beckett		2a. DATE OF DEATH MONTH DAY YEAR May 15, 1987		2b. HOUR 3:00 P.M.	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 16 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 557-36-7645		17. INFORMANT ADDRESS George Beckett 1701 N. Eutaw Place	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>					1 Week
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Carcinoma</u>					6 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asthma, Chronic Obstructive Pulmonary Disease</u>					
19a. DATE OF OPERATION 3/6/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1987, to May 15, 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 15, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <i>Mitchell Rothenberg</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell Rothenberg		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/21/87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 21 1987	



Handwritten text, likely a signature or date, appearing in the bottom right corner of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713277

REG. NO.

FOR
STATE
REGISTRAR

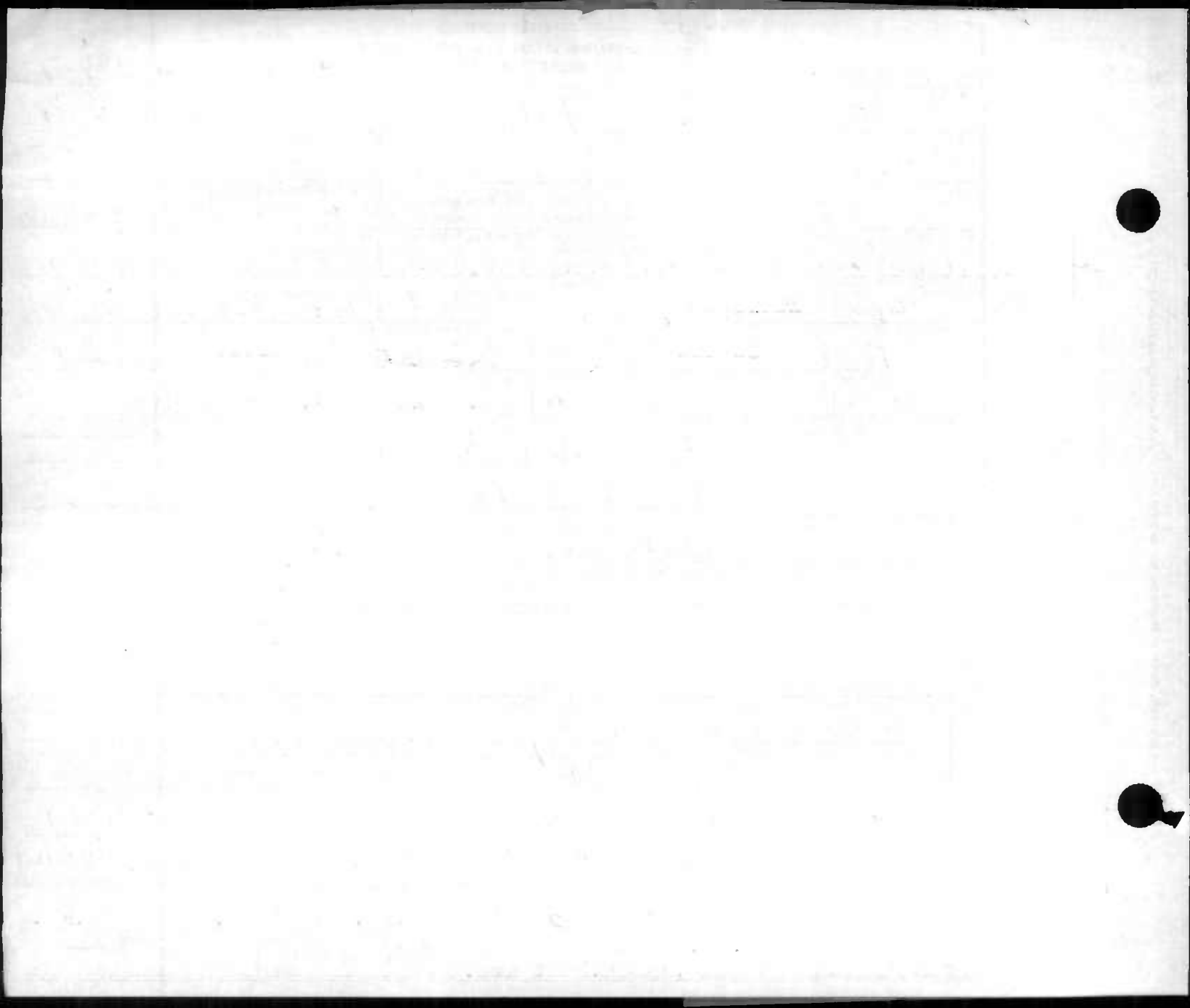
1. DECEASED NAME (TYPE OR PRINT) Charles L. Bell			2a. DATE OF DEATH MONTH DAY YEAR 5 2 87		2b. HOUR 4:55 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 15 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical.		12b. KIND OF BUSINESS OR INDUSTRY Contractor
13a. STATE MD			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank ----- Bell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Rose ----- Everhart		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 232-21-5549		17. INFORMANT ADDRESS Mrs. Glenn Bell, Same as above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Gastrointestinal. Bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF: (b). Possible ulceration of Duodenum or dissecting aortic aneurysm		
DUE TO, OR AS A CONSEQUENCE OF: (c). Metastatic Cancer of lung		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/1 19 87 to 5/2 19 87 , that (I) (we) lost saw the deceased alive on 5/2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Soychel Chon				22c. DATE SIGNED 5/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Song Chol CHON, M.D.				22e. ADDRESS 3001 S. Homover st. Baltimore, MD 21223	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/5/1987	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard Co. Md.
24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			25. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE MAY 6 1987 Julia Gordon-Randall

BP



052939 MAY 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 2 7 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Elizabeth Bellman			2a. DATE OF DEATH MONTH DAY YEAR 05 - 07 - 87		2b. HOUR 0514 ^A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 - 14 - 06		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BALTIMORE CITY OR COUNTY OF DEATH Balto. City		9b. BALTIMORE CITY OR COUNTY OF DEATH Balto. City		9c. BALTIMORE CITY OR COUNTY OF DEATH Balto. City		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY --		13a. STATE Maryland		13b. COUNTY Baltimore		
13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1018 Courtney Road 21227		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Kehring		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Kemp		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 216-18-6760		17. INFORMANT Wayne Bellman		17. ADDRESS 107 Patricia Ave. 21090		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) INFERIOR WALL MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Vascular Disease						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary Embolus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/7 , 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.		22b. SIGNATURE W. Blake Kutsche M.D.		
22c. DATE SIGNED 5/7/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. BLAKE KUTSCHE		22e. ADDRESS ST AGNES HOSPITAL 900 CATON AVE. BALTI MD 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/11/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		24. ADDRESS 4107 Wilkens Ave. 21229		
25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE Julia Henderson-Randall		25c. REGISTRAR'S SIGNATURE Julia Henderson-Randall		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MAY 8 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713279

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		5 17 1987		9:30 a.m.	
Edwin G. Bennett							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR 9 27 1924		62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Binghamton, New York		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		1101 N. Calvert St.		Episco. Priest		Religious	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		1101 N. Calvert St. 21202			
Charles Edwin Bennett		Helen Grow Nichols					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWII		003-18-4838		Rev. Lyman Farnham, 1409 Bolton St. 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Cardiac arrest		minutes	
		DUE TO, OR AS A CONSEQUENCE OF		(b) Acute myocardial Infarction		minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c) coronary artery disease		10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>now</u> 19 <u>85</u> to <u>5/16</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Dr. G. William Benedict, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Dr. G. William Benedict		2 W. University Pkwy.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation		May 20, 1987		Greenmount Crematory		Balto. COUNTY MD.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
		Mitchell-Wiedefeld, 6500 York Rd. 21212		Balto., Md.		MAY 20 1987	
						25b. REGISTRAR'S SIGNATURE	
						Julia Benson-Baker	

7

Handwritten text at the bottom left, possibly a signature or date.

52932 MAY 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
RELEASED NON MED DR. ZANE PER MR. FREEMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR					REG. NO. 13280								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST FRANKLIN BERGER					2a. DATE OF DEATH MONTH DAY YEAR MAY 6, 1987			2b. HOUR MIN 3:55 P					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lineman		12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3035 Janice Avenue, 21230				
14. FATHER'S NAME FIRST MIDDLE LAST Emil Berger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn ADAMS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-09-5250		17. INFORMANT ADDRESS Stanley Hollowak, 3202 Bryant Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>left heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ischemic heart disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>miss</u> <u>1 day</u> <u>4 mos.</u>			
19a. DATE OF OPERATION 5/5/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Heart failure</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5/5 1987 to 5/6 1987, that (I) (we) last saw the deceased alive on 5/6 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/6/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FONGER				22e. ADDRESS JHH 600 N WOLFE ST.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland						
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,				25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

1. *Journal of Management Education*, 2000, 24(1), 1-10.
 2. *Journal of Management Education*, 2000, 24(1), 11-20.
 3. *Journal of Management Education*, 2000, 24(1), 21-30.

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Item # 7719789cg F.H. Film G653

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna MIDDLE: LAST: Bernstein			2a. DATE OF DEATH MONTH: 5 DAY: 3 YEAR: 87			2b. HOUR 7:39 PM			
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH MONTH: 1 DAY: 1 YEAR: 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unk Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sm. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13a. STATE MD		13b. COUNTY BCITY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5900 Park Heights Ave. 21215	
14. FATHER'S NAME FIRST: LOUIS MIDDLE: LAST: C OHEN			15. MOTHER'S MAIDEN NAME FIRST: ANNA MIDDLE: LAST: MORMAR			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unk NO			
16b. SOCIAL SECURITY NO. 082-09-1833			17. INFORMANT ADDRESS: SONDR A. WILLNER 3920 NEMO RD. (21133)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest - pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 29, 1987</u> to <u>May 3, 1987</u> , that (I) (we) last saw the deceased alive on <u>May 3, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mary J. Nijden MD						DEGREE MD		22c. DATE SIGNED 5-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary J. Nijden MD						22e. ADDRESS Sm. Hospital of Baltimore MD 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL / REMOVAL			23b. DATE 5/5/87		23c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEM		23d. LOCATION CITY OR TOWN COUNTY STATE FLUSHING, L.I.N.Y.		
24. FUNERAL DIRECTOR NAME: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)						25a. DATE REC'D. BY REGISTRAR MAY 13 1987			
						25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

BP

02317

1. The first part of the document is a list of names and dates. The names are written in a cursive script, and the dates are in a more formal, printed style. The list appears to be a record of some kind, possibly a ledger or a list of transactions.

2. The second part of the document is a table with several columns. The columns are headed with names and dates, and the rows contain numerical data. The table is organized in a way that suggests it is a record of some kind, possibly a ledger or a list of transactions.

3. The third part of the document is a list of names and dates, similar to the first part. The names are written in a cursive script, and the dates are in a more formal, printed style. The list appears to be a record of some kind, possibly a ledger or a list of transactions.

4. The fourth part of the document is a table with several columns. The columns are headed with names and dates, and the rows contain numerical data. The table is organized in a way that suggests it is a record of some kind, possibly a ledger or a list of transactions.

5. The fifth part of the document is a list of names and dates, similar to the first part. The names are written in a cursive script, and the dates are in a more formal, printed style. The list appears to be a record of some kind, possibly a ledger or a list of transactions.

6. The sixth part of the document is a table with several columns. The columns are headed with names and dates, and the rows contain numerical data. The table is organized in a way that suggests it is a record of some kind, possibly a ledger or a list of transactions.

7. The seventh part of the document is a list of names and dates, similar to the first part. The names are written in a cursive script, and the dates are in a more formal, printed style. The list appears to be a record of some kind, possibly a ledger or a list of transactions.

8. The eighth part of the document is a table with several columns. The columns are headed with names and dates, and the rows contain numerical data. The table is organized in a way that suggests it is a record of some kind, possibly a ledger or a list of transactions.

9. The ninth part of the document is a list of names and dates, similar to the first part. The names are written in a cursive script, and the dates are in a more formal, printed style. The list appears to be a record of some kind, possibly a ledger or a list of transactions.

10. The tenth part of the document is a table with several columns. The columns are headed with names and dates, and the rows contain numerical data. The table is organized in a way that suggests it is a record of some kind, possibly a ledger or a list of transactions.

053878

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5-12-87 1258
13282

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Thomas BETHS			2a. DATE OF DEATH MONTH DAY YEAR 5 12 87			2b. HOUR M				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 16 17		6. AGE (IN YEARS (LAST BIRTHDAY)) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. 9 MD.				
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED TAILOR		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5523 BELLVILLE AVE 21207	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM T BETHS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. EVANS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-06-4994	
17. INFORMANT So ANN BETHS			ADDRESS 5523 BELLVILLE AVE							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Acute MI.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) CAD

DUE TO, OR AS A CONSEQUENCE OF

(c) First MI 1977APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

260y.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>5-12-87</u> to <u>5-12-87</u> , that (1) (we) last saw the deceased alive on <u>5-12-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>PETER GROSZMAN</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-15-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER GROSZMAN				22e. ADDRESS 1777 REISTERSTOWN RD PINEVILLE, 21208			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY MD. NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL 21208	
24. FUNERAL DIRECTOR NAME ADDRESS BETHS FUNERAL HOME 1129 N. CAROLINE				25a. MAY 15 1987 BY REGISTRAR'S SIGNATURE			

2000-01-01

053265 MAY

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

1 3 2 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE BEVERLY			2a. DATE OF DEATH MONTH DAY YEAR 5 5 87		2b. HOUR 805 P M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 6 14 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTIMORE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crown Lock & Seal Copper Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE Beverly LAST Porter		15. MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE Porter LAST Porter		13e. STREET ADDRESS / ZIP CODE 2911 THORNDALE AVENUE 21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-146329		17. INFORMANT M. GOTTLIES ADDRESS BALTIMORE AT GREENSPRINGS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (c) HYPOTHERMIA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. SEPSIS, COPD, PNEUMONIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/5 87 to 5/8 87 , that (I) (we) last saw the deceased alive on 5/5 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael J. Gottlieb		DEGREE MD		22c. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Gottlieb		22e. ADDRESS BALTIMORE AT GREENSPRINGS BALTIMORE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/12/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL Md.	
24. FUNERAL DIRECTOR NAME March Funeral Home		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR MAY 11 1987	25b. REGISTRAR'S SIGNATURE Antia Davis

MEDICAL CERTIFICATION

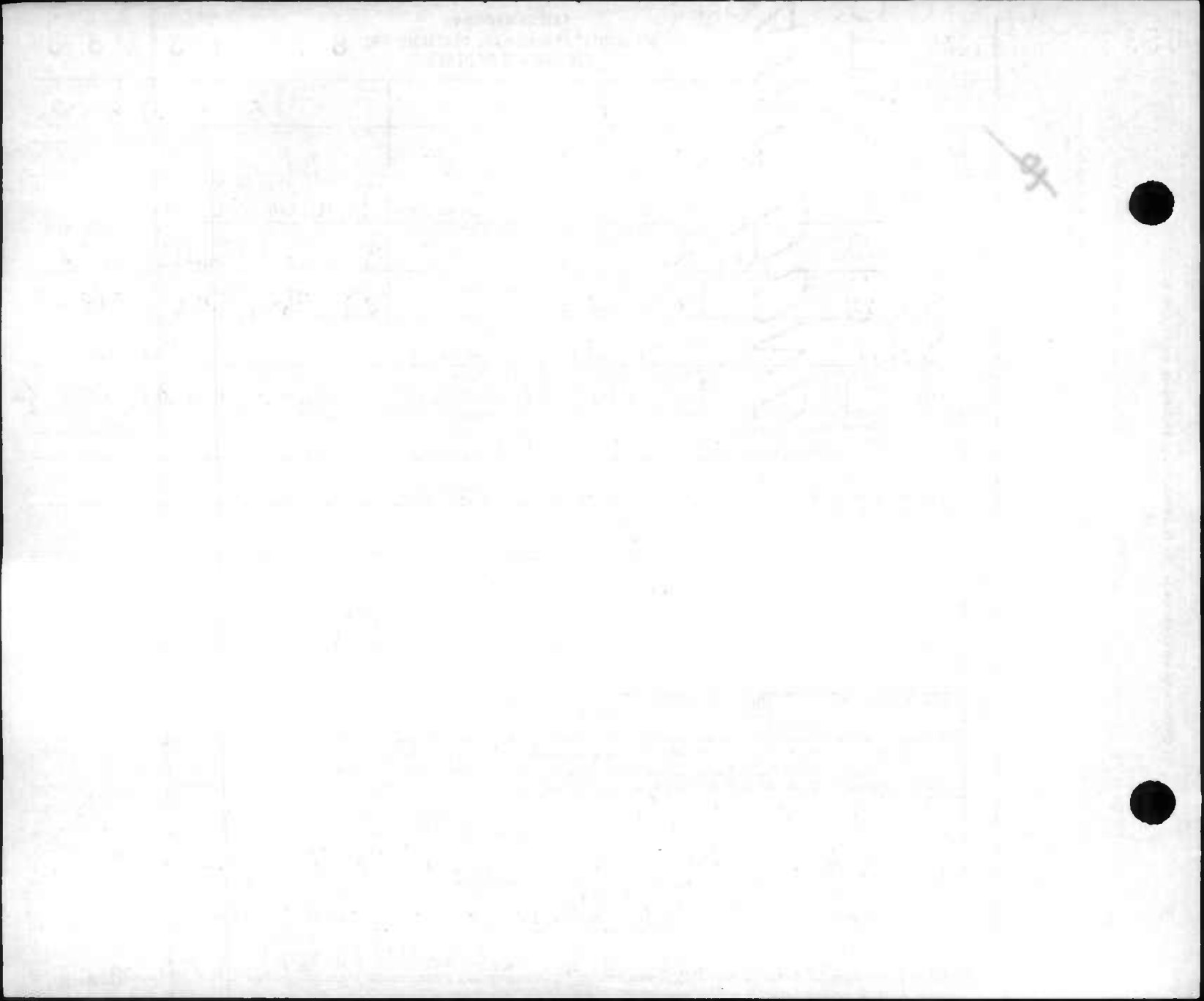
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP _____

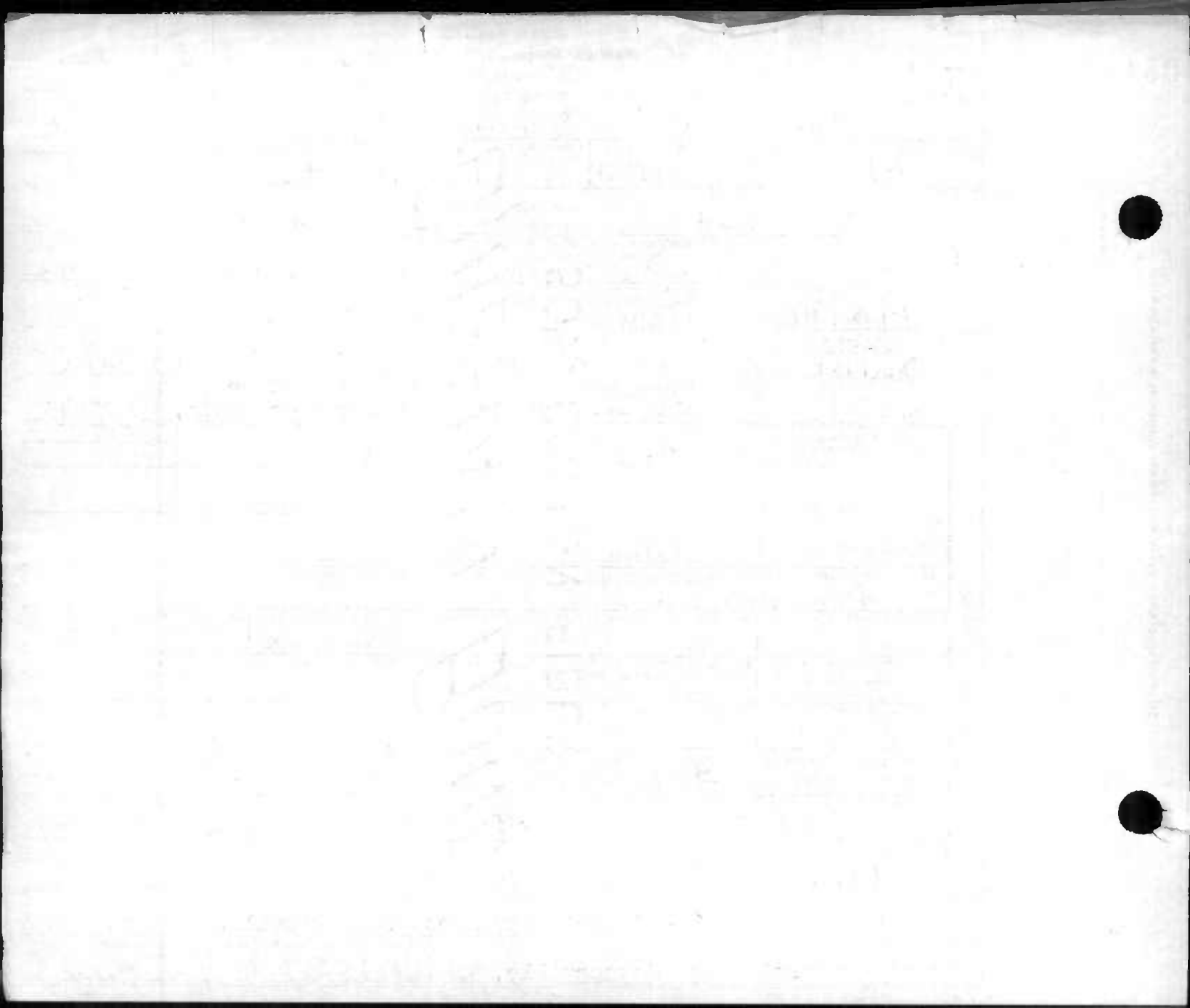
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>HARI</u> LAST <u>BHASIN</u> <u>Hari K Bhasin</u>		2a. DATE OF DEATH MONTH <u>5</u> DAY <u>17</u> YEAR <u>87</u> <u>5/17/87</u>		2b. HOUR <u>550</u> A.M.
3. SEX <u>MALE</u> <u>M</u>	4. RACE <u>INDIAN</u> <u>Indian (ASIA)</u>	5. DATE OF BIRTH MONTH <u>6</u> DAY <u>1</u> YEAR <u>44</u> <u>6/1/44</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>42</u> YRS IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS. HOURS _____ MIN. _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>INDIA</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD.
10. CITY OR TOWN OF DEATH <u>Balto</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ of Maryland Cancer Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Physician</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Practice</u>
13a. STATE <u>MD</u>		13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Columbia</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE <u>6924 Carlinda Ave</u>		21046		
FATHER'S NAME FIRST <u>DAULAT</u> MIDDLE <u>RAM</u> LAST <u>BHASIN</u> <u>Daulat R Bhasin</u>		15. MOTHER'S MAIDEN NAME FIRST <u>KAUSHALYA</u> MIDDLE <u>DEVI</u> LAST <u>CHADHA</u> <u>Kaushalya Chadha</u>		
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		14b. SOCIAL SECURITY NO. <u>023-4803037</u> <u>025-48-3037</u>		
14c. IF YES, GIVE WAR OR DATES		17. INFORMANT <u>5456 New Grange Garth</u> <u>Ramesh Khurana Columbia, MD 21045</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>bilateral pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pancytopenia</u>				
19a. DATE OF OPERATION <u>5/17/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/87</u> 19 <u>87</u> , to <u>5/17/87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/17/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Austin MA</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/17/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AUSTIN MA</u>		22e. ADDRESS <u>22 S. Greene, Balto, MD 21202</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>05-18-87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Balto. MD</u>	
24. FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home</u>		ADDRESS <u>Catonsville, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 19 1987</u>
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



053653 MAY 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13285

1. DECEASED NAME (TYPE OR PRINT) ISIDORE Isadore Birenbaum			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 5 9 19 87			2b. HOUR M 2:48P		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAR. 23, 1911	6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 5 9 19 87	2d. HOUR M	7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		10. KIND OF BUSINESS OR INDUSTRY TAILOR
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY TAILOR		
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB MORRIS BIRENBAUM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FEIGA MALA BIRENBAUM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-26-6634		17. INFORMANT ADDRESS 21215 MRS. ROSE BIRENBAUM 4143 CRESTHEIGHTS RD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Gunshot wound of head</u> (handgun) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:50xx 5 6 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4143 Crest Heights Rd. Balto. City, MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE <i>Margareta A. Korell</i>	TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	DATE SIGNED 5/10/87
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.	ADDRESS 111 Penn St. Balto. MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/11/87	23c. NAME OF CEMETERY OR CREMATORY RUDOMER VEREIN - CEMETERY-ROSEDALE BALTIMORE	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR MAY 15 1987	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

1 2582

HERB M. TUDOR



1 2582

054147 MAY 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara M. Biscoe			2a. DATE OF DEATH MONTH DAY YEAR 5 19 87		2b. HOUR 12:35 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 1 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Alice Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST William Newton Byers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-10-4624A		17. INFORMANT ADDRESS Gloria Schweigman 3626 Malden Ave. 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DEHYDRATION DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from Aug 19 86 to 5-19-87 , that (I) (we) last saw the deceased alive on 5-15-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE [Signature]		DEGREE		22b. DATE SIGNED 5/19/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. PRABHAKAR MD		22e. ADDRESS 333 S EAST AVE BAL MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.		ADDRESS 3818 Roland Ave. 21211		25a. DATE REC'D. BY REGISTRAR MAY 19 1987	
		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Page: _____
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

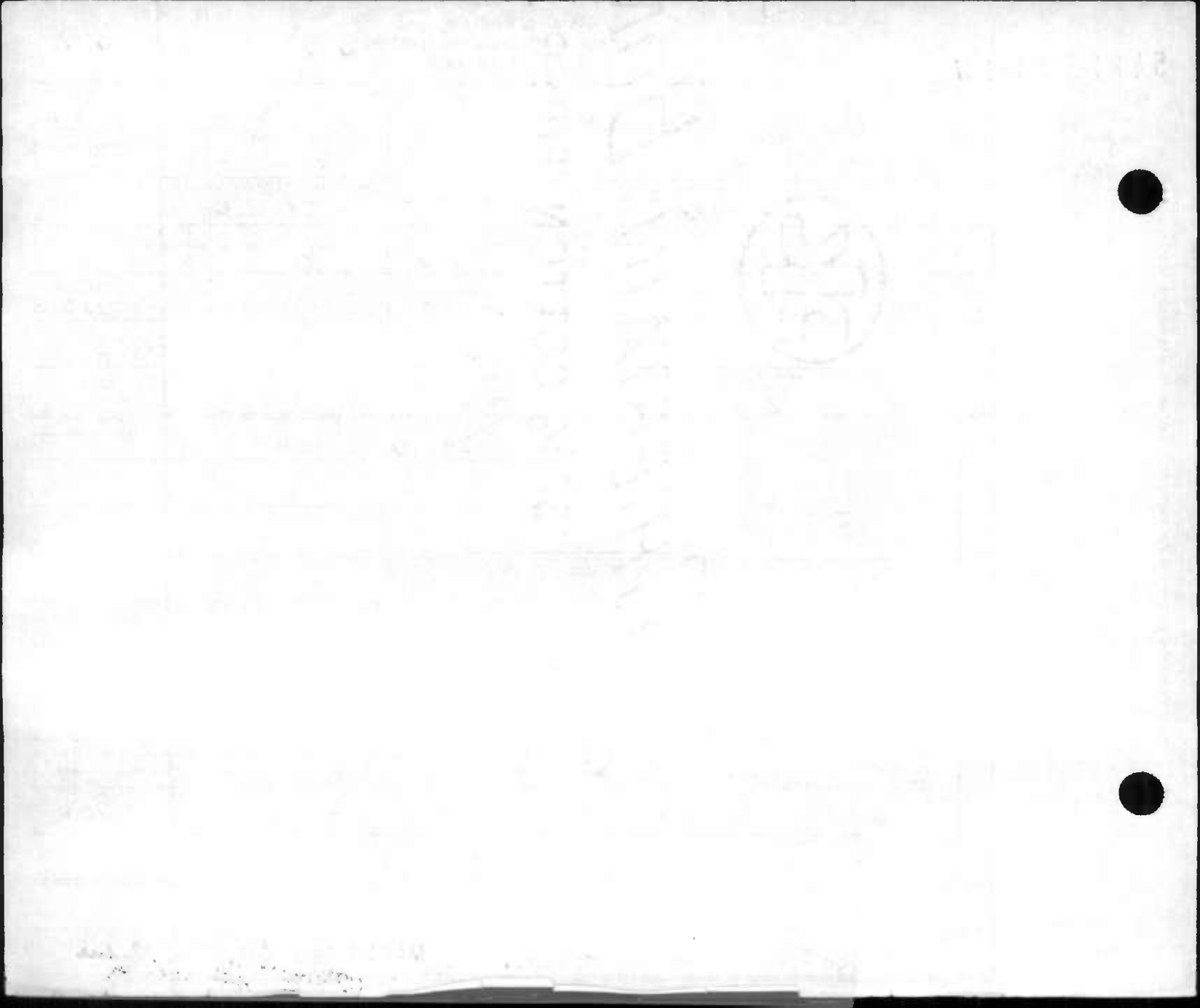
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 1 3 2 8 /

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Bivins Baby Boy</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>5-6-87</i>		2b. HOUR <i>4 AM</i>	
3 SEX <i>male</i>	4 RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5-6-87</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>0 0 2 35</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ø</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ø</i>
13a. STATE <i>MD.</i>		13b. COUNTY <i>Balt.</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>B. Nicole Bivins</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>Ø</i>		17. INFORMANT <i>hospital staff mercy</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (24 wk gestation)</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>No known conditions</i>					
19a. DATE OF OPERATION <i>Ø</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ø</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>NA</i> 19 <i>87</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>NA</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>Ø</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>N.A.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/6/87</i> , 19 <i>87</i> , to <i>5/6/87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>5/6/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Eileen Eberst</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>5/6/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Eileen Eberst</i>		22e. ADDRESS <i>6320 Resistor Ct Columbia MD 21045</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>5-21-87</i>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR <i>MAY 28 1987</i>			
24. FUNERAL DIRECTOR NAME <i>State Anatomy Board</i>		ADDRESS <i>Balto., MD.</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place same in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 1 3 2 8 8																			
1. FOR STATE REGISTRAR				TWIN B																			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Keara								Payne		May 12, 1987								12:10AM					
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				IF UNDER 24 HRS			
Female				Black				MONTH DAY YEAR				YRS.				MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				USA				MAY 11 87				Baltimore City				MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				Maryland General Hospital				Infant															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS / ZIP CODE							
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				755 W. Lexington Ave. 908				21201			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
FIRST MIDDLE LAST				FIRST MIDDLE LAST				No				-				Kathereen Bizzell				908			
																Clara L. Cox 755 W. Lexington St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]				STREET				CITY OR TOWN				COUNTY STATE							
22a. I certify that (x) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>87</u> , to <u>May 12</u> , 19 <u>87</u> , that (x) (we) lost saw the deceased alive on <u>May 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (do not) view the body after death.																							
22b. SIGNATURE												DEGREE				22c. DATE SIGNED							
<u>Robert Ottenritter</u>																5/12/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS											
Robert Ottenritter, M.D.												c/o Maryland General Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE							
Burial				5/15/87				Cedar Hill				Ann Arundel, Co.											
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS												MAY 14 1987											
Wm. C. March F/H 1101 E. North Ave.																							

BP 12

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U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must complete pages 4 and 5 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

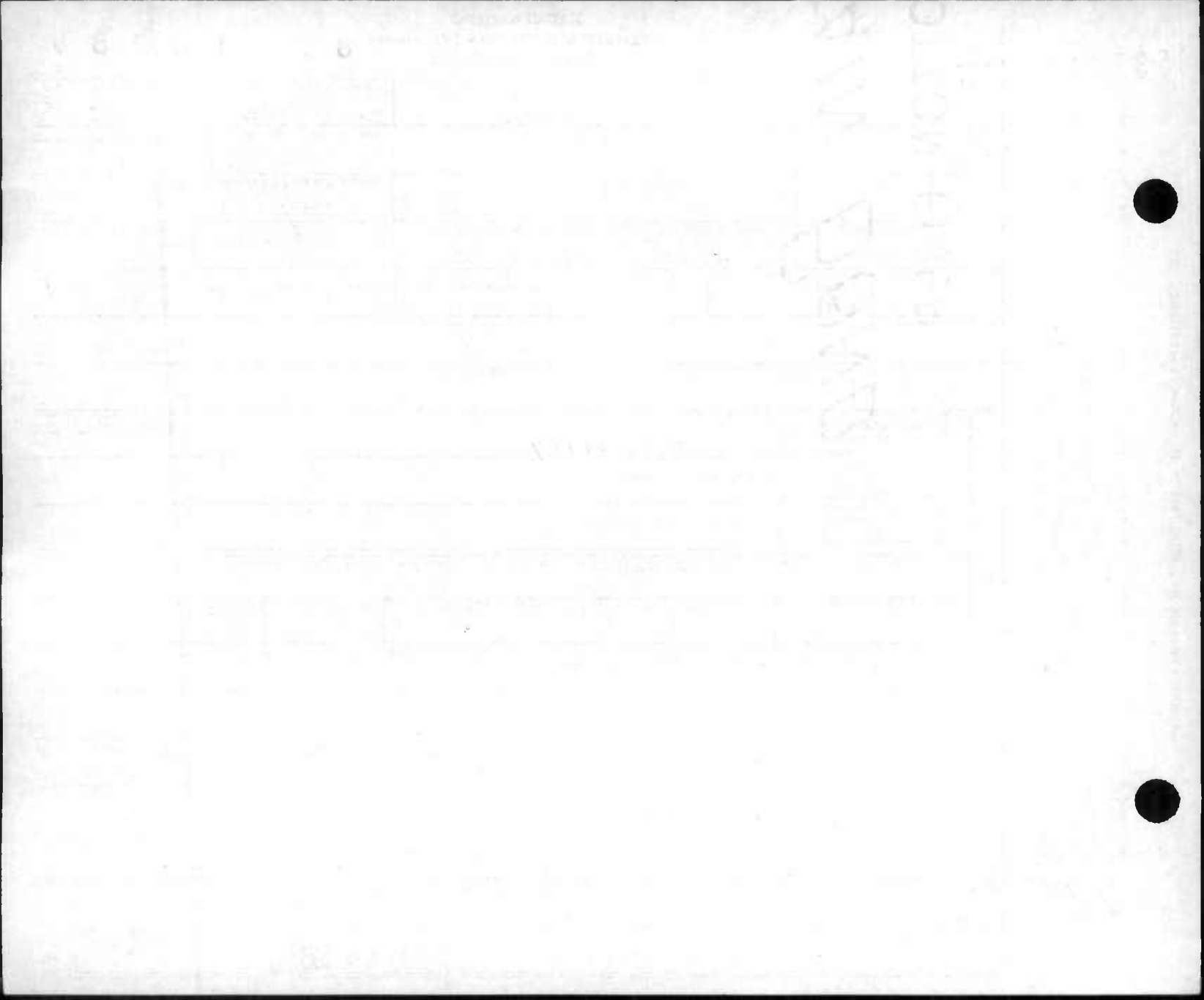
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1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Teara</i> <i>Bizzell</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>May 11, 1987</i>		2b. HOUR <i>11:50^P</i>	
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 11 87</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>1 8</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>N/A</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Kathereen Bizzell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>Clara Cox 755 W. Lexington St. Apt. 908</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PREMATURITY</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 11</i> , 19 <i>87</i> , to <i>May 11</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>May 11</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE <i>Robert Ottenritter M.D.</i>				22c. DATE SIGNED <i>5/12/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Ottenritter, M.D.</i>				22e. ADDRESS <i>c/o Maryland General Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/15/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ann Arundel, Co.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 14 1987</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm. March F/H 1101 E. North Ave.</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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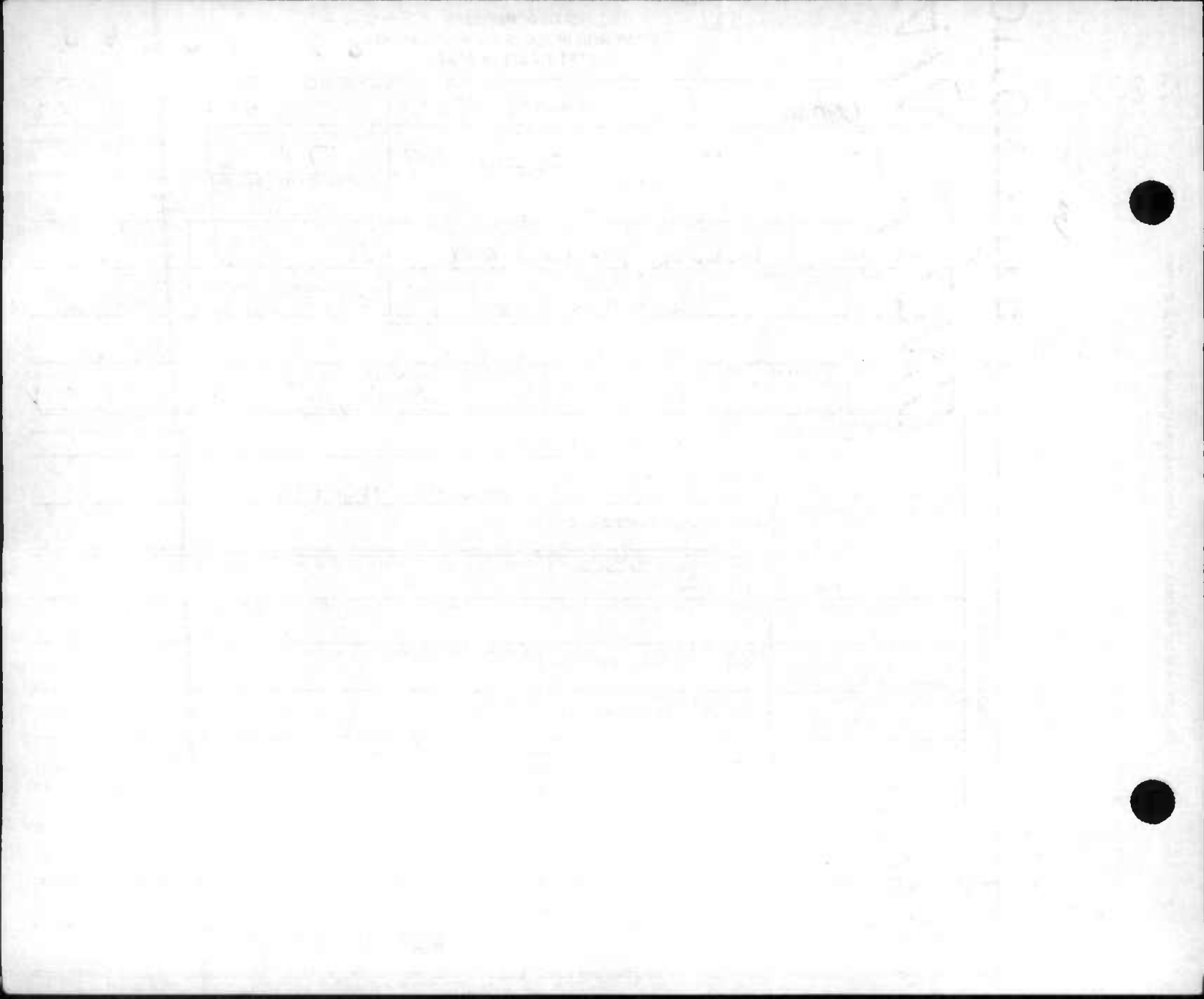
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13290

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Oshia May BLACKWELL</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-4-87</i>		2b. HOUR <i>4:15 A</i>
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 24 09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Liberty Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md</i>		13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>2503 Violet Avenue</i> <i>21215</i> <i>Apt 303</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Howie</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ola Howie</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-44-8374</i>		17. INFORMANT NAME ADDRESS <i>Linda B. Bright 8836 Pennsbury Place</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>ACUTE MYOCARDIAL ISCHEMIA</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>RENAL FAILURE</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-25</i> , 19 <i>87</i> , to <i>5-4</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>5-4</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Burt Duong</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5-4-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BICH T DUONG</i>		22e. ADDRESS <i>LIBERTY MEDICAL CENTER.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>5/7/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mount Calvary Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Anne Arundel Co Md</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H West</i>		4300 Wabash Avenue		25. DATE RECEIVED BY REGISTRAR <i>MAY 6 1987</i>	
				26. REGISTRAR'S SIGNATURE <i>John J. Kane</i>	



054877 JUN 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REED I BLACKBURN					2a. DATE OF DEATH MONTH DAY YEAR 5 19 87					2b. HOUR 9:45 AM		
3. SEX male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 26 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7814 WYNBROOK ROAD 21224	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BLACKBURN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE DAMRON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 404 343484		17. INFORMANT CHART		ADDRESS 3001 S. HANOVER ST. BALTIMORE MD 21230						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 87 , to 5-19 , 19 87 , that (I) (we) last saw the deceased alive on 5-19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John D. Melto				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. MELTO				22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE, M.D.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Baltimore Maryland						
24. FUNERAL DIRECTOR NAME Connelly Funeral Home				ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rodgers				

BP

MEMORANDUM FOR THE DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

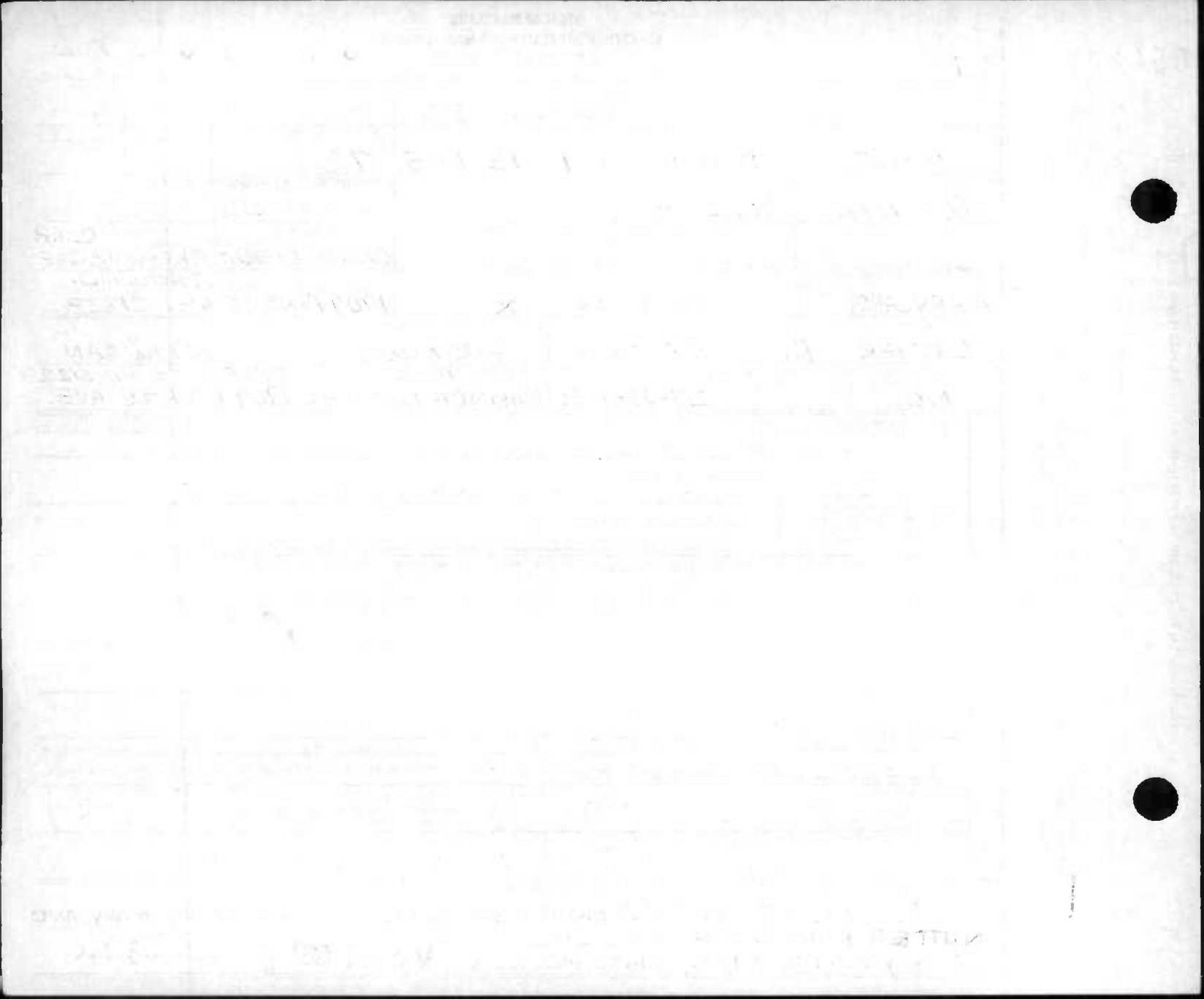
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 1 3 2 9 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) LUTHER BLACKWELL JR.				2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1987				2b. HOUR 5:00 a.m.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 13 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY CORP. KERR-McGEE		
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BALTO, MD. 1909 PENROSE AVE. 21223				
14. FATHER'S NAME FIRST MIDDLE LAST LUTHER R. BLACKWELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE STRAUGAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 217-07-4056		17. INFORMANT MRS. MARINDA BLACKWELL ADDRESS BALTIMORE, MD. 21223 1909 PENROSE AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>METASTATIC SQUAMOUS CELL CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OBSTRUCTION OF LEFT MAIN BRONCHUS WITH TUMOR</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from <u>May 19, 1987</u> to <u>May 20, 1987</u> , that (X) (we) lost saw the deceased alive on <u>May 20, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (by we) (did) (do not) view the body after death.								
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/20/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. D. PERRY				22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/29/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		
24. FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTO, MD. 21216				25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



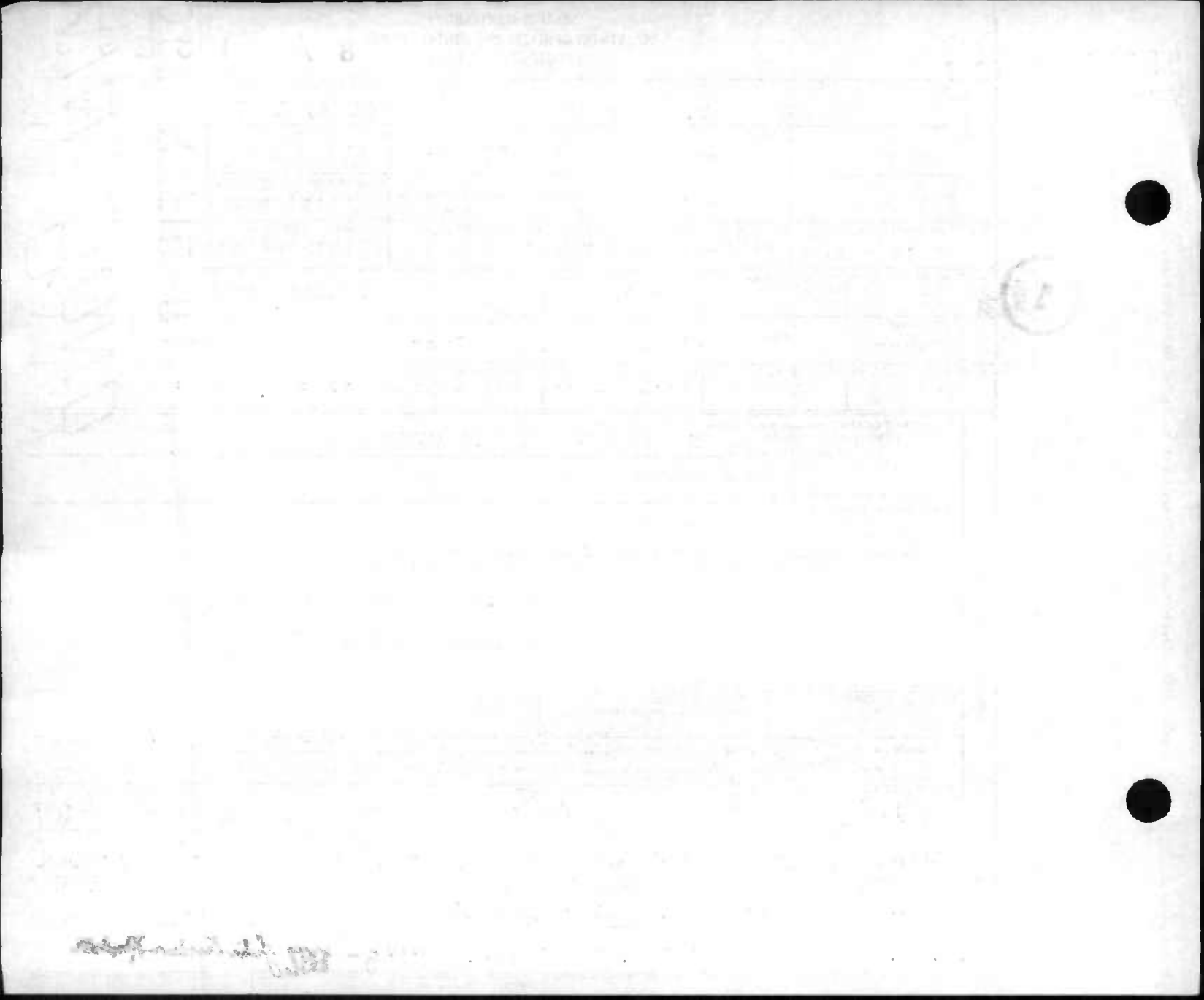
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 13293				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD F. BLAND					2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1987				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 31 26		6. AGE (IN YEARS LAST BIRTHDAY) 61		7b. HOUR 2:10 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1633 N. Washington St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Bland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Harris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 227-36-6719		17. INFORMANT ADDRESS Edith Bland 1633 N. Washington St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 2, 87, to MAY 4, 87, saw the deceased alive on MAY 4, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Adel S. El-Hennawy				DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adel S. El-Hennawy				22e. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN Owings Mills		COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 5 - 1987			
				25b. REGISTRAR'S SIGNATURE John Burdon					



054956 JUN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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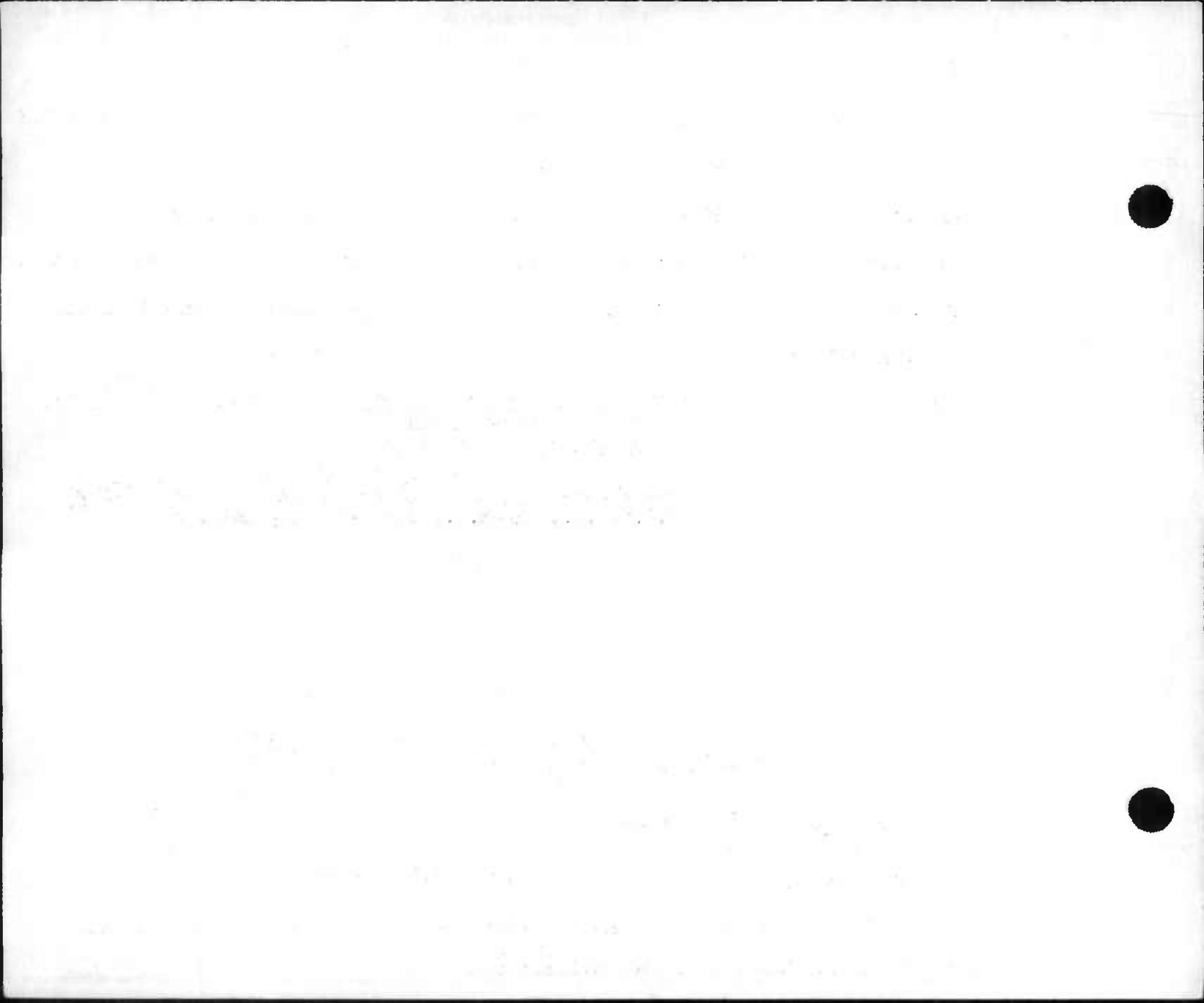
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JOHN		O.		BLENACH				5		23		87				6:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		WHITE		12 23 1910		76 YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2914 Stricker Street		Welder		Brandt/Koppers											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2914 Stricker Street		21223							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
UNKNOWN		UNKNOWN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		217-01-9230		Charles R. Clarke, Jr.		3488 Uniontown Rd.		21187									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a).		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Sudden death		A.S.C.V.D., Old-M.I., Cardiac Arrhythmia.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from		19		to		19		that (I) (we) lost									
saw the deceased alive on		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
George Androv, MD.				5/													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
		3350 Wilkens Avenue															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		5/27/87		Lakeview Mem. Pk.		Sykesville		Carroll		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Hubbard Funeral Home, Inc.		21229 4107 Wilkens Ave.		MAY 28 1987		L. A. Davidson-Rudolph											



053387 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

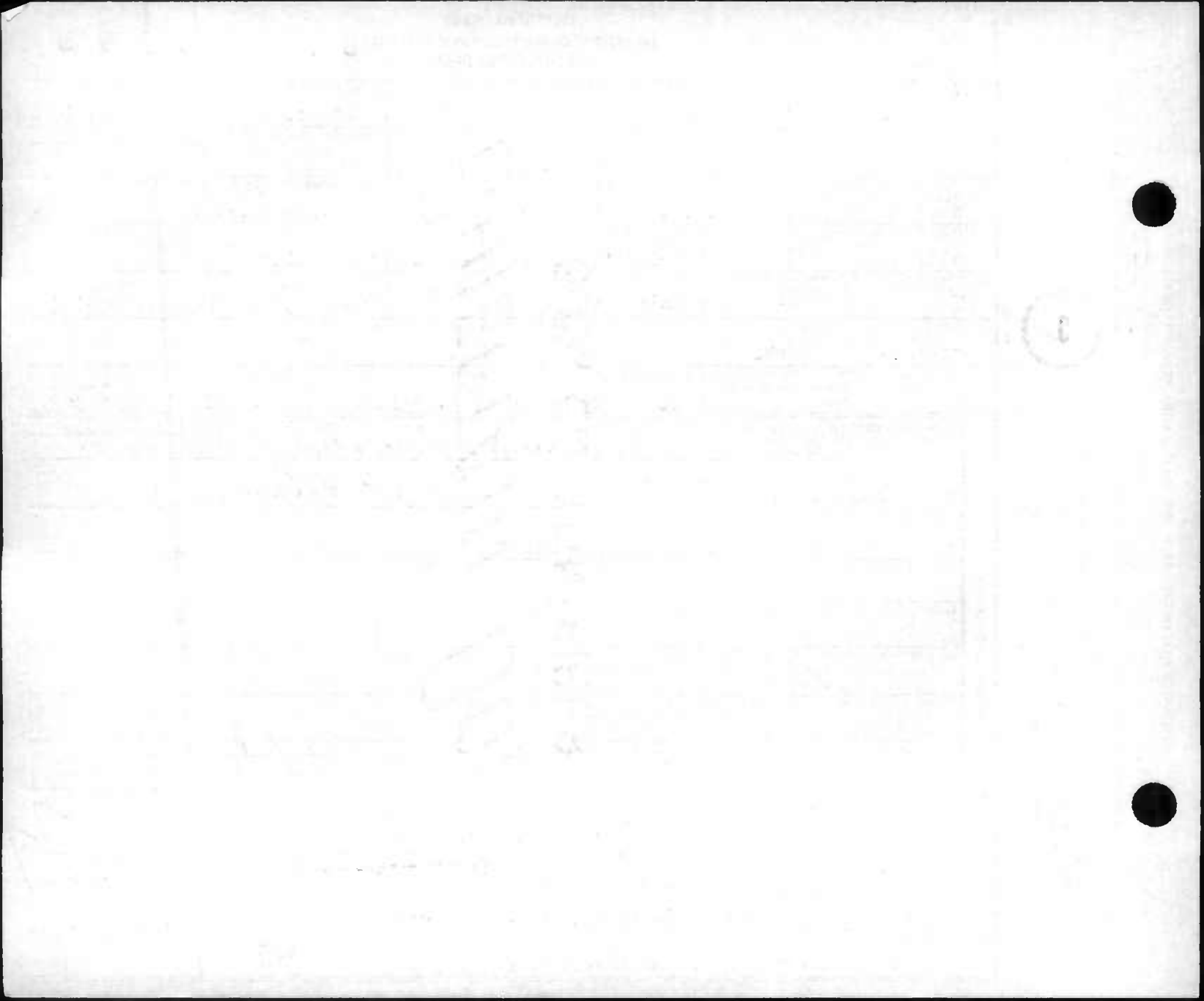
8 7 1 3 2 9 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruby May Blizzard				2a. DATE OF DEATH MONTH DAY YEAR May 8, 1987		2b. HOUR 8:43PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1317 Roland Heights Avenue 21211				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Garfield Parks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith		13e. STREET ADDRESS / ZIP CODE 1317 Roland Heights Avenue 21211			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 18 6501		17. INFORMANT ADDRESS Jerry F. Blizzard 21211 1317 Roland Heights Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/14/74 to 5/8 19 87 , that (I) (we) last saw the deceased alive on 5/1/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Dr. Mark Dugan				DEGREE MD		22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mark Dugan				22e. ADDRESS 500 W. W. W. Street 15 E. Biddle Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/12/87		23c. NAME OF CEMETERY OR CREMATORY Lorriane Park cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home, 3631 Falls Road 21211				25a. DATE REC'D. BY REGISTRAR MAY 12 1987			
				25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of this page. Page 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

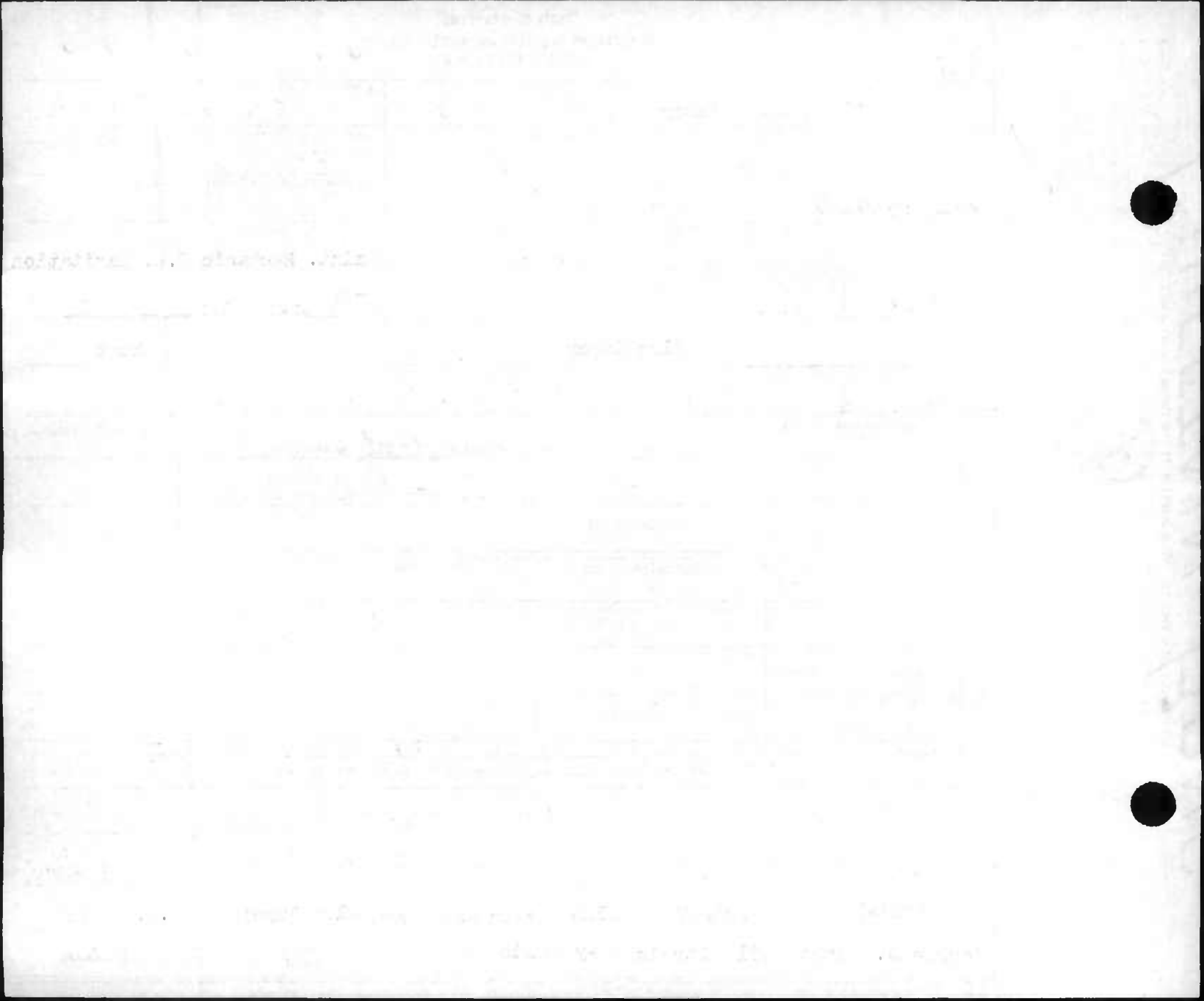
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713296

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Henry Blockinger		2a. DATE OF DEATH MONTH DAY YEAR 05-24-87		2b. HOUR 7:55 PM	
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 03-01-16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint. Mechanic		12b. KIND OF BUSINESS OR INDUSTRY B.C. Sanitation
13a. STATE Md		13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Blockinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Ebert		13e. STREET ADDRESS / ZIP CODE 325 West Arden Road 21225	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 212105949		17. INFORMANT Ruth M. Blockinger. Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prob. Ac. Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HTN					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> 19 <u>87</u> to <u>5-24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>Shobha Reddy</u>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHOBHA REDDY		22e. ADDRESS 300 HOSPITAL, SUITE 230 GLEN BURNIE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md		23e. DATE REC'D. BY REGISTRAR MAY 28 1987			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

1 3 2 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL May BLUM			2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1987			2b. HOUR 7:15AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE Maryland			13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 135 N. Curley St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Sheriril			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)			16. ADDRESS Baltimore, MD.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 219-28-8052		17. INFORMANT Charles A. Lusby, Sr.		920 Calwell Rd. 21229				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NATURAL CAUSE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DEHYDRATION</u> ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS RIGHT UPPER LOBE AND LOWER LOBE</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from MAY 15, 19 87, to MAY 21, 19 87, that (b) (we) saw the deceased alive on MAY 21, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) we (did) (did not) view the body after death.										
22b. SIGNATURE A.F. Narzemi MD			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.F. NARZEMI M.D.			22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 26, 87		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD.			
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, Maryland 21206			25a. DATE REC'D. BY REGISTRAR MAY 25 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

10

WAS 2 1901

055409 JUN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE LANE BOERSTLER JR.			2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1987		2b. HOUR P 2:08 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1964		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Instrument Mechanic Gas Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Monrovia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George L. Boerstler, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Grunewald			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-96-4680		17. INFORMANT ADDRESS George L. Boerstler, Sr. Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPOTENSION / BRAIN DEATH DUE TO, OR AS A CONSEQUENCE OF (c) HYPERAMMONEMIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Graft versus Host Disease, Renal Failure, Liver Failure, Lung infiltrates					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>5/01/87</u> , 19 <u>87</u> , to <u>5/29/87</u> , 19 <u>87</u> , that (I) <u>did not</u> last saw the deceased alive on <u>5/29/87</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.					
22b. SIGNATURE 		DEGREE M.D.		22c. DATE SIGNED 5/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALKIS G. TOGIATIS		22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.,		ADDRESS Damascus, Md.		25a. DATE REC'D BY REGISTRAR JUN 3 1987	
				25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

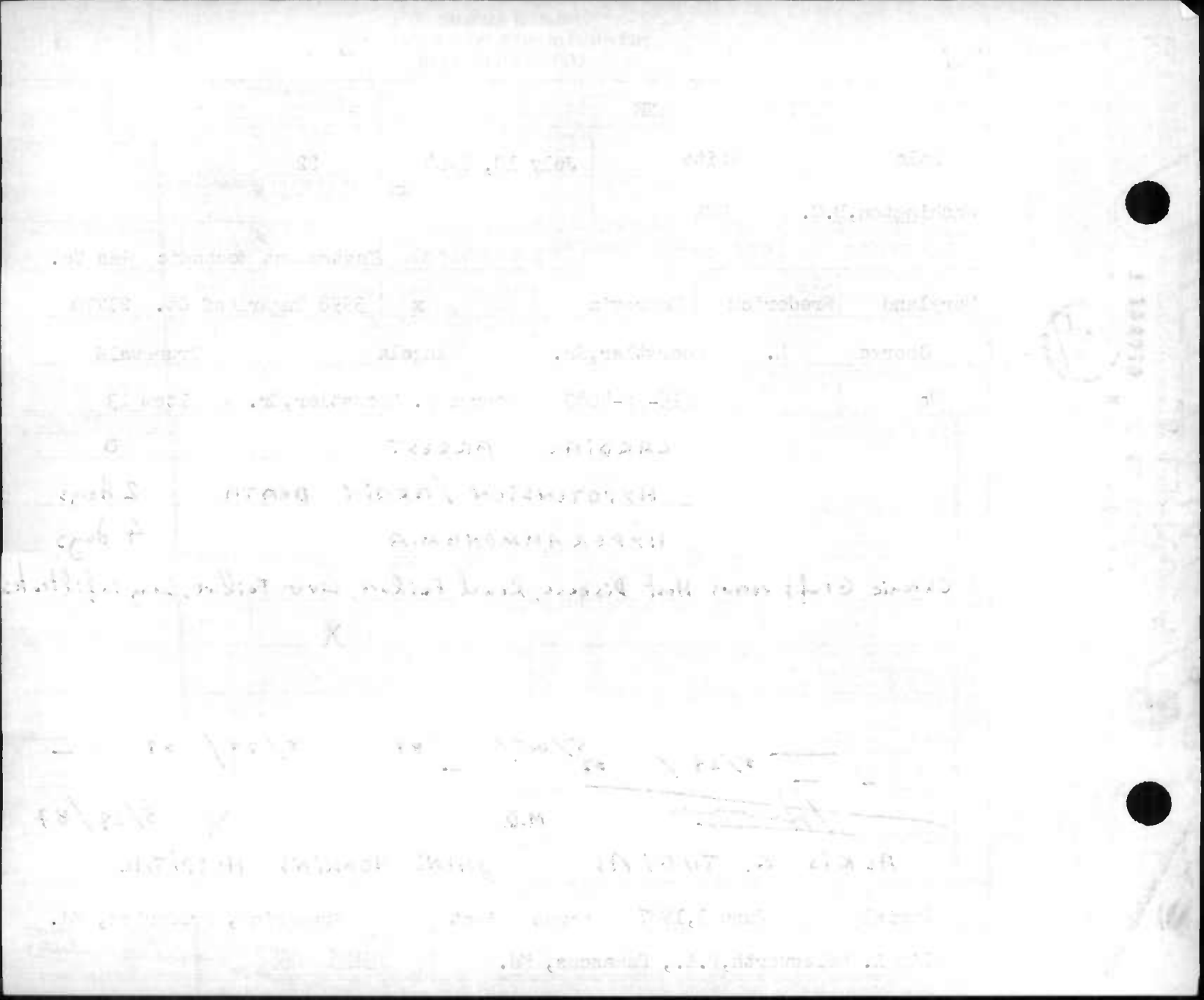
BOERSTLER JR., GEORGE L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



53457 MAY 14 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 2 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura LEE Bonds			2a. DATE OF DEATH MONTH DAY YEAR 5/6/87		2b. HOUR 2:50P	
3. SEX female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 25 31		6. AGE (IN YEARS LAST BIRTHDAY) 55	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHERS AIDE		12b. KIND OF BUSINESS INDUSTRY PUBLIC SCHOOLS	
13a. STATE MD		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3724 COLUMBUS DRIVE BALTIMORE, MD 21215	
14. FATHER'S NAME FIRST MIDDLE LAST LEVI THOMAS STARVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE GERTRUDE HUNTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-28-7460		17. INFORMANT MR. JOHN G. BONDS ADDRESS BALTIMORE, MO. 3724 COLUMBUS DR. 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic prostatic cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) (to liver)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO						
19a. DATE OF OPERATION 4/9/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED prostatic ca		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/26 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 5/6 1987		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3/26 1987		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5/6 1987		
22a. I certify that (I) (this hospital) attended the deceased from 5/6 1987 to 5/6 1987 that (I) (we) last saw the deceased alive on 5/6 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Gloria C. Johnson MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gloria C. Johnson		22e. ADDRESS Sinai Hospital of Baltimore				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/12/1987	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.	
24. FUNERAL HOME NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216				25a. DATE REC'D. BY REGISTRAR MAY 13 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodgers

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwritten notes and markings are visible across the page.]

053005 MAY 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13300

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
DANIEL C. BOOKER				5 11 19 87				M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE	BLACK	3 4 1905	82 YRS.	MONTHS DAYS	HOURS MIN	5 14 19 87		7:32 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
VIRGINIA	U. S. A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		1711 W. North Ave.			WAITER		RESTAURANT		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
MARYLAND		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1711 W. NORTH AVE. 21217					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST			FIRST MIDDLE LAST						
NATHANIEL BOOKER			MARY ALICE DODSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		214-20-7292A		MRS. DARLIE QUINNEY 10 WILLOWMERE AVE. MONTCLAIR, N.J. 07042					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
Ann M. Dixon, M.D.		Deputy Chief		5-15-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Ann M. Dixon, M.D.		111 Penn St., Balto., MD		21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		5/18/1987		CEDAR HILL CEMETERY		BALTIMORE, MARYLAND			
24. FUNERAL HOME OR OTHER PLACE OF INTERMENT		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
2501 GWYNNS FALLS PKWY. BALTO., MD. 21216		MAY 18 1987		Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 2, AND TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. CERTAIN PAGE # FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

4



100-10200

100-10200

100

100-10200

053367

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN M. BOOKER			2a. DATE OF DEATH MONTH DAY YEAR 5/10/87		2b. HOUR 11.05 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 14 08		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS. MONTHS DAYS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST JACK JENKINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA WRIM		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-09-4044		17. INFORMANT ADDRESS MR. ELLIS BOOKER 1726 N. WOLFE ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Hours						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 87 , to 5/10 , 19 87 , that (I) (we) last saw the deceased alive on 5/10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/10/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR HUIE		22e. ADDRESS GOOD SAMARITAN HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-15-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS		
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME		ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR MAY 12 1987		
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results achieved. It is a general overview of the work done and the results achieved.

2. The second part of the report deals with the specific work done during the year. It is a detailed account of the work done and the results achieved. It is a detailed account of the work done and the results achieved.

3. The third part of the report deals with the financial situation of the country. It is a summary of the financial situation and the progress of the work during the year. It is a summary of the financial situation and the progress of the work during the year.

4. The fourth part of the report deals with the social situation of the country. It is a summary of the social situation and the progress of the work during the year. It is a summary of the social situation and the progress of the work during the year.

5. The fifth part of the report deals with the economic situation of the country. It is a summary of the economic situation and the progress of the work during the year. It is a summary of the economic situation and the progress of the work during the year.

6. The sixth part of the report deals with the political situation of the country. It is a summary of the political situation and the progress of the work during the year. It is a summary of the political situation and the progress of the work during the year.

7. The seventh part of the report deals with the cultural situation of the country. It is a summary of the cultural situation and the progress of the work during the year. It is a summary of the cultural situation and the progress of the work during the year.

8. The eighth part of the report deals with the educational situation of the country. It is a summary of the educational situation and the progress of the work during the year. It is a summary of the educational situation and the progress of the work during the year.

9. The ninth part of the report deals with the health situation of the country. It is a summary of the health situation and the progress of the work during the year. It is a summary of the health situation and the progress of the work during the year.

10. The tenth part of the report deals with the environment situation of the country. It is a summary of the environment situation and the progress of the work during the year. It is a summary of the environment situation and the progress of the work during the year.



53587 MAY 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 13302

1. DECEASED NAME (TYPE OR PRINT) ANNE R. BOONE			2a. DATE OF DEATH MONTH DAY YEAR May 10, 1987		2b. HOUR 12:15P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 15, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Roland Park Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) IncomeTaxAuditor		12b. KIND OF BUSINESS OR INDUSTRY IRS
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles McCourt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ziegler		13e. STREET ADDRESS / ZIP CODE 4137 Roland Ave. 21211	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-44-8771		17. INFORMANT ADDRESS Catherine B. Glenn 908 Malvern Ave. Ruxton Md 21204	

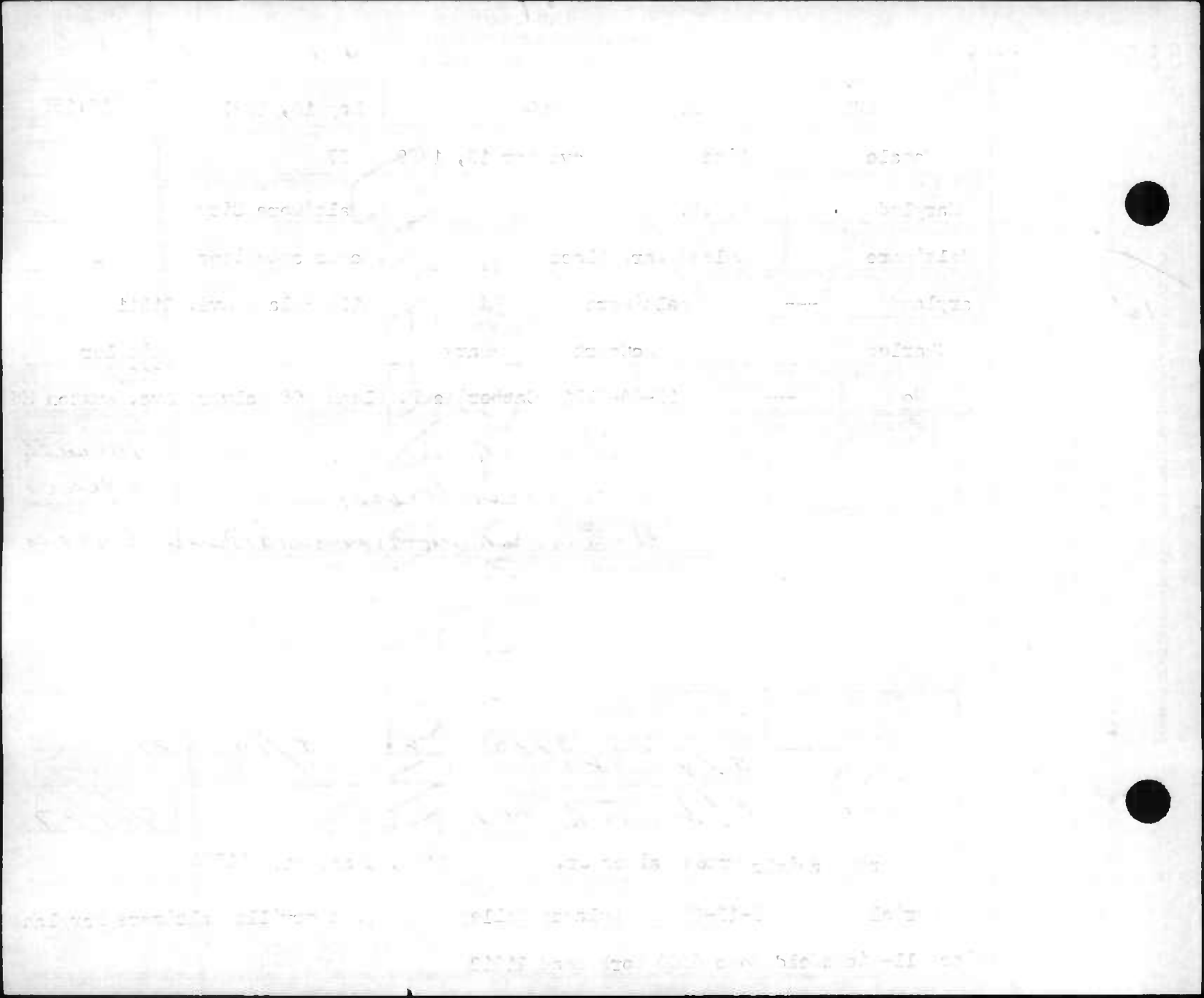
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 years</u> <u>5 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>83</u> , to <u>5/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>J. M. Gaines Jr.</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>5/4/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Myrton Gaines Jr.		22e. ADDRESS 7800 York Road 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-13-87	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR MAY 14 1987 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

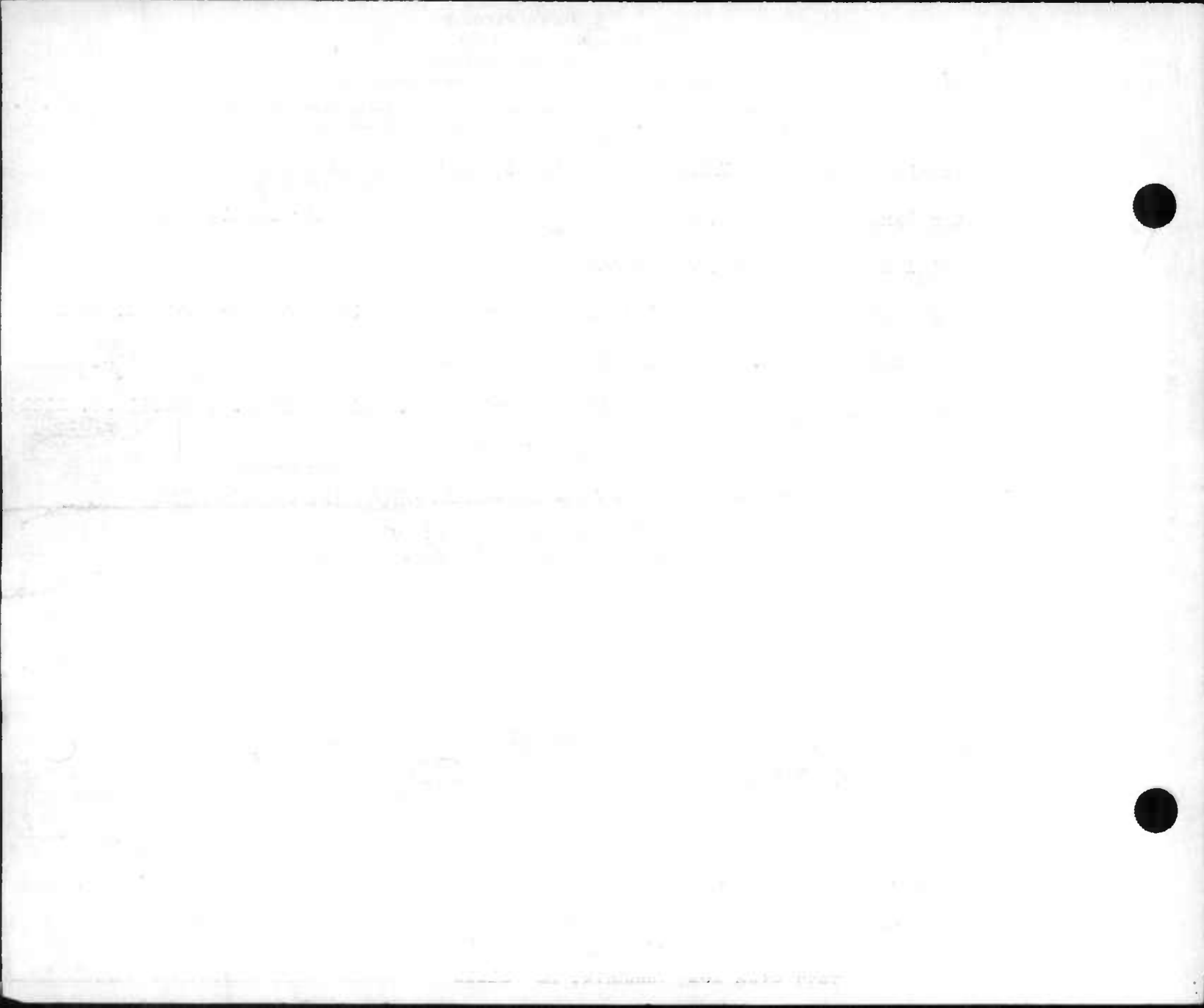
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 0 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
1. FOR STATE REGISTRAR		CATHERINE R. BOOZ		Female		White		May 23, 1907		80 YRS.		Maryland		USA				Baltimore City		Baltimore		Church Hospital		Sales		Hutzler's	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		431 South Cornwall St. 21224																			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
Andrew C. Wilfer		Martha Lang		No		214-12-1788		Dolores M. White		430 S. Cornwall St. 21224																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		HEART FAILURE		DUE TO, OR AS A CONSEQUENCE OF		XNESEASE																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b)		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		DUE TO, OR AS A CONSEQUENCE OF																			
				(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PNEUMONIA																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
		HOUR A.M. MONTH DAY YEAR																									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION																							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN		COUNTY		STATE																			
22a. I certify that (1) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED																			
saw the deceased alive on		MAY 25, 1987		MAY 25, 1987		MAY 25, 1987		that (1) (we) last																			
above, (1) (we) (did) (did not) view the body after death.																											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																									
A.F. NAZEMI M.D.		CHURCH HOSPITAL CORPORATION																									
		100 W BROADWAY BALTIMORE, MD. 21231																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																					
Burial		5-29-87		Oak Lawn		Baltimore Maryland																					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																					
Duda-Ruck Funeral Home of Dundalk		7922 Wise Ave. Dundalk, MD 21222		MAY 27 1987																							

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEAN		FIRST K.		MIDDLE Borkowicz		2a. DATE OF DEATH MONTH 05 DAY 14 YEAR 87		2b. HOUR 8²⁵ AM	
3. SEX F. Female		4. RACE W. White		5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9B Maidstone Ct./21237	
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 134/09/9546		17. INFORMANT ADDRESS Balto., Md. 21237 Catherine E. Erlbeck /9A Maidstone Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial reinfarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a - ADVANCED CARCINOMA OF STOMACH S/P RESECTION									
19a. DATE OF OPERATION 2/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. OF STOMACH		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/12 19 87 to 5/14 19 87 that (I) (we) last saw the deceased alive on 5/13 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE KABARIA R.P.		DEGREE M.P.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KABARIA R.P.		22e. ADDRESS CHURCH HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 5/16/1987		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Towson Balto., Md.			
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Balto., Md. 21222				25a. DATE REC'D. BY REGISTRAR MAY 15 1987		25b. REGISTRAR'S SIGNATURE John D. ...			

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RECEIVED
OFFICE OF THE
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MAY 15 1987

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REG. NO.

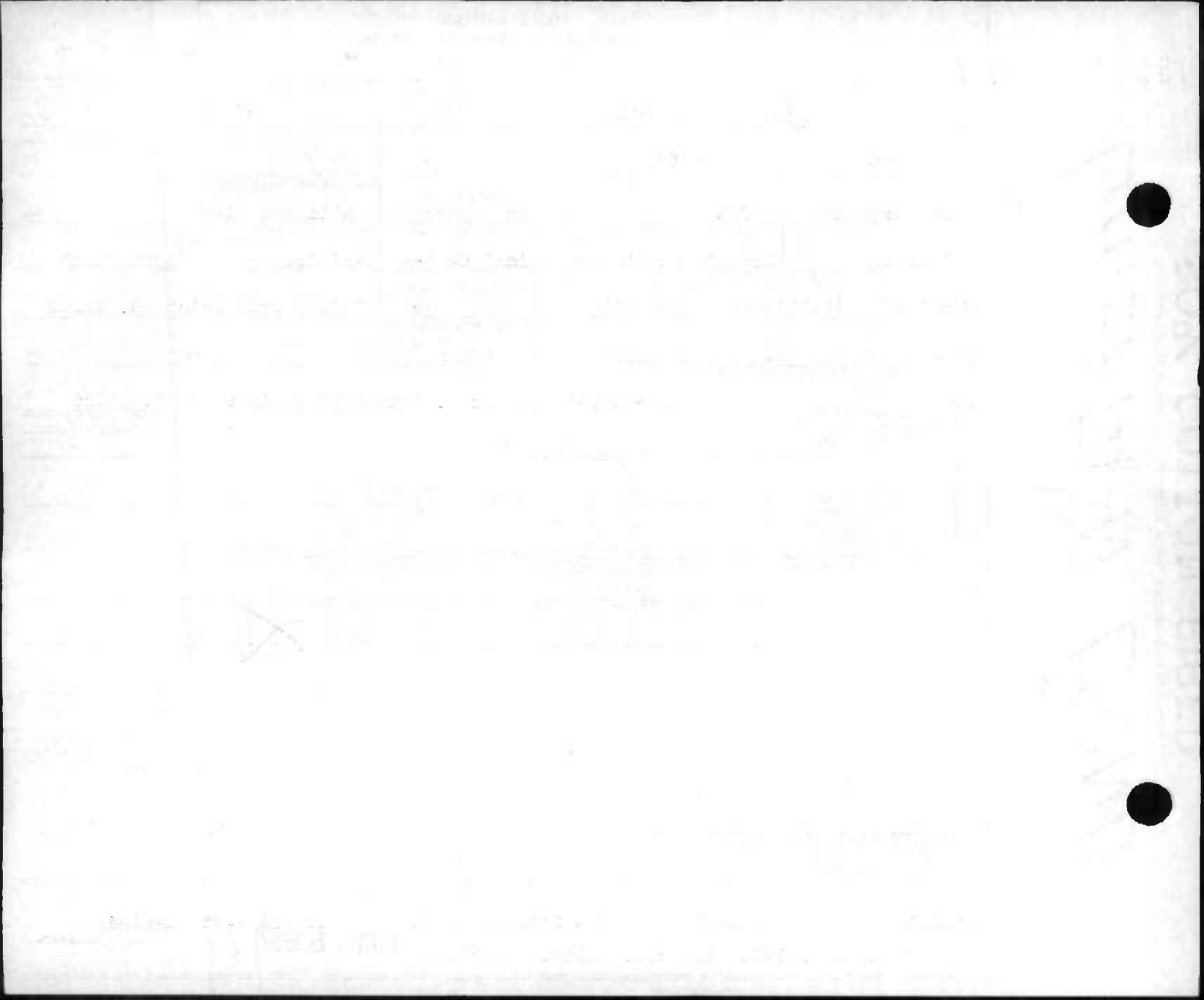
1. DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE EARL	LAST BORROR	2. DATE OF DEATH		MONTH 05	DAY 01	YEAR 1987	2b. HOUR 7¹⁵ PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 07 DAY 13 YEAR 32		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7609 Merrit Point Rd. 21222					
14. FATHER'S NAME FIRST James MIDDLE H. LAST Borrer						15. MOTHER'S MAIDEN NAME FIRST Ada MIDDLE LAST Judy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-48-3111		17. INFORMANT ADDRESS James D. Borrer 6926 Birdwood Rd. 21220									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Liver failure, sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <u>4.12</u> 19 <u>87</u> to <u>5.1</u> 19 <u>87</u> that (we) lost saw the deceased alive on <u>5.1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>A. Umbricht</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/1/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Umbricht						22e. ADDRESS FSK 17C							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-5-87		23c. NAME OF CEMETERY OR CREMATORY John Idleman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Scheri West Virginia							
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Ave. Balto., Md 21222						25a. DATE AND D. BY REGISTRY MAY 5 1987		25b. REGISTRAR'S SIGNATURE <i>John Duda-Ruck</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13306

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth E. Bostic			2a. DATE OF DEATH MONTH DAY YEAR 5 13 87		2b. HOUR 927a		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 2 - 46		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aid		12b. KIND OF BUSINESS OR INDUSTRY N. Home	
13a. STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Chaney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13e. STREET ADDRESS / ZIP CODE 4707 Pilgrim Rd. 21214			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-46-0062		17. INFORMANT ADDRESS James Bostic 4707 Pilgrim Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) 5 hrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/13/87 , 19____, to 5/13/87 , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE P. Kusan MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEISER				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-18-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cnty.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24. FUNERAL DIRECTOR NAME Randolph J. Collick				ADDRESS 2431 E. Oliver St.		25a. DATE REC'D. BY REGISTRAR MAY 19 1987	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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4-10-15-17-19-21-23-25-27-29-31-33-35-37-39-41-43-45-47-49-51-53-55-57-59-61-63-65-67-69-71-73-75-77-79-81-83-85-87-89-91-93-95-97-99-101-103-105-107-109-111-113-115-117-119-121-123-125-127-129-131-133-135-137-139-141-143-145-147-149-151-153-155-157-159-161-163-165-167-169-171-173-175-177-179-181-183-185-187-189-191-193-195-197-199-201-203-205-207-209-211-213-215-217-219-221-223-225-227-229-231-233-235-237-239-241-243-245-247-249-251-253-255-257-259-261-263-265-267-269-271-273-275-277-279-281-283-285-287-289-291-293-295-297-299-301-303-305-307-309-311-313-315-317-319-321-323-325-327-329-331-333-335-337-339-341-343-345-347-349-351-353-355-357-359-361-363-365-367-369-371-373-375-377-379-381-383-385-387-389-391-393-395-397-399-401-403-405-407-409-411-413-415-417-419-421-423-425-427-429-431-433-435-437-439-441-443-445-447-449-451-453-455-457-459-461-463-465-467-469-471-473-475-477-479-481-483-485-487-489-491-493-495-497-499-501-503-505-507-509-511-513-515-517-519-521-523-525-527-529-531-533-535-537-539-541-543-545-547-549-551-553-555-557-559-561-563-565-567-569-571-573-575-577-579-581-583-585-587-589-591-593-595-597-599-601-603-605-607-609-611-613-615-617-619-621-623-625-627-629-631-633-635-637-639-641-643-645-647-649-651-653-655-657-659-661-663-665-667-669-671-673-675-677-679-681-683-685-687-689-691-693-695-697-699-701-703-705-707-709-711-713-715-717-719-721-723-725-727-729-731-733-735-737-739-741-743-745-747-749-751-753-755-757-759-761-763-765-767-769-771-773-775-777-779-781-783-785-787-789-791-793-795-797-799-801-803-805-807-809-811-813-815-817-819-821-823-825-827-829-831-833-835-837-839-841-843-845-847-849-851-853-855-857-859-861-863-865-867-869-871-873-875-877-879-881-883-885-887-889-891-893-895-897-899-901-903-905-907-909-911-913-915-917-919-921-923-925-927-929-931-933-935-937-939-941-943-945-947-949-951-953-955-957-959-961-963-965-967-969-971-973-975-977-979-981-983-985-987-989-991-993-995-997-999-1001-1003-1005-1007-1009-1011-1013-1015-1017-1019-1021-1023-1025-1027-1029-1031-1033-1035-1037-1039-1041-1043-1045-1047-1049-1051-1053-1055-1057-1059-1061-1063-1065-1067-1069-1071-1073-1075-1077-1079-1081-1083-1085-1087-1089-1091-1093-1095-1097-1099-1101-1103-1105-1107-1109-1111-1113-1115-1117-1119-1121-1123-1125-1127-1129-1131-1133-1135-1137-1139-1141-1143-1145-1147-1149-1151-1153-1155-1157-1159-1161-1163-1165-1167-1169-1171-1173-1175-1177-1179-1181-1183-1185-1187-1189-1191-1193-1195-1197-1199-1201-1203-1205-1207-1209-1211-1213-1215-1217-1219-1221-1223-1225-1227-1229-1231-1233-1235-1237-1239-1241-1243-1245-1247-1249-1251-1253-1255-1257-1259-1261-1263-1265-1267-1269-1271-1273-1275-1277-1279-1281-1283-1285-1287-1289-1291-1293-1295-1297-1299-1301-1303-1305-1307-1309-1311-1313-1315-1317-1319-1321-1323-1325-1327-1329-1331-1333-1335-1337-1339-1341-1343-1345-1347-1349-1351-1353-1355-1357-1359-1361-1363-1365-1367-1369-1371-1373-1375-1377-1379-1381-1383-1385-1387-1389-1391-1393-1395-1397-1399-1401-1403-1405-1407-1409-1411-1413-1415-1417-1419-1421-1423-1425-1427-1429-1431-1433-1435-1437-1439-1441-1443-1445-1447-1449-1451-1453-1455-1457-1459-1461-1463-1465-1467-1469-1471-1473-1475-1477-1479-1481-1483-1485-1487-1489-1491-1493-1495-1497-1499-1501-1503-1505-1507-1509-1511-1513-1515-1517-1519-1521-1523-1525-1527-1529-1531-1533-1535-1537-1539-1541-1543-1545-1547-1549-1551-1553-1555-1557-1559-1561-1563-1565-1567-1569-1571-1573-1575-1577-1579-1581-1583-1585-1587-1589-1591-1593-1595-1597-1599-1601-1603-1605-1607-1609-1611-1613-1615-1617-1619-1621-1623-1625-1627-1629-1631-1633-1635-1637-1639-1641-1643-1645-1647-1649-1651-1653-1655-1657-1659-1661-1663-1665-1667-1669-1671-1673-1675-1677-1679-1681-1683-1685-1687-1689-1691-1693-1695-1697-1699-1701-1703-1705-1707-1709-1711-1713-1715-1717-1719-1721-1723-1725-1727-1729-1731-1733-1735-1737-1739-1741-1743-1745-1747-1749-1751-1753-1755-1757-1759-1761-1763-1765-1767-1769-1771-1773-1775-1777-1779-1781-1783-1785-1787-1789-1791-1793-1795-1797-1799-1801-1803-1805-1807-1809-1811-1813-1815-1817-1819-1821-1823-1825-1827-1829-1831-1833-1835-1837-1839-1841-1843-1845-1847-1849-1851-1853-1855-1857-1859-1861-1863-

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13307

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	M
JOHN		NONE	Boulware		05/17/87					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALC	B	01 02 11		76		YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.
S.C.	U.S.			B.Cth						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE	Bon Secours Hospital									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE						
MD		BALTO	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1008 Mosher ST 21217						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS						
William Boulware		Senora Jamison								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
		249-16-8337		Jessie Boulware		4405 Dunland Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis - due to infected abdominal aortic aneurysm and perforated.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMPLICATION GIVEN IN PART 1: <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
5/13/87		AORTO-DUODENAL FISTULA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.		22b. SIGNATURE <u>K. Parikh</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
K. PARIKH, MD.		4713 Leads Ave Arbutus Md 21227								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		5/24/87		Unknown		South Carolina				
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. Wainwright		2700 Edmondson Ave.				MAY 19 1987		Julia Davidson-Randall		

BP

OLD WATER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

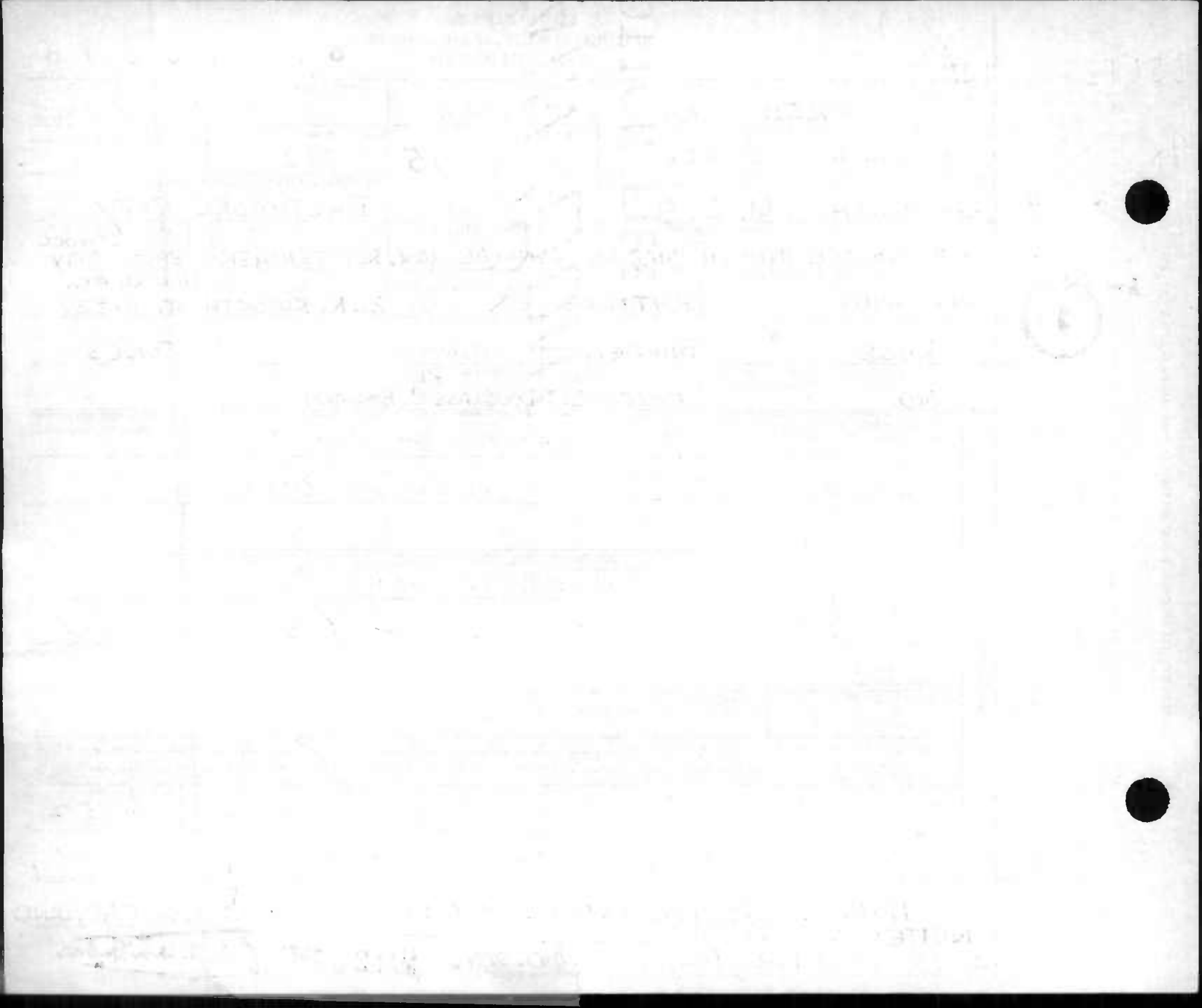
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713308
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARION B. BOWMAN		2a. DATE OF DEATH MONTH DAY YEAR 5 16 87		2b. HOUR 11:40 A	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 24 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSP.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL		12c. BALTO. CITY	
13a. STATE MARYLAND		13b. COUNTY 13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROSS BARDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE JONES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO.	
16b. SOCIAL SECURITY NO. 215-12-3833		17. INFORMANT REV. DOUGLASS C. BOWMAN		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 881 IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) ELECTROMECHANICAL DISSOCIATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RT. HIP FRACTURE HX TOES					
19a. DATE OF OPERATION 5/5/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DISPLACED SUBCAPITAL (RH) HIA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 5/3/87 to 5/16/87 , that (we) last saw the deceased alive on 5/16/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE A. Woreta		DEGREE MD		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHHEW		22e. ADDRESS WORETA NORTH CHARLES GEN. HOSPITAL		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/21/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		24. FUNERAL HOME NAME ADDRESS WATER FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216			
25a. DATE REC'D. BY REGISTRAR MAY 20 1987		25b. REGISTRAR'S SIGNATURE Julia D. [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713309

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond Bowman			2a. DATE OF DEATH MONTH DAY YEAR May 1 1987			2b. HOUR 9:45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-4-20		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE No fixed address		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
16a. Inkn.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Previous Cardiopulmonary Arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myocardial Infraction, Tracheostomy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from March 3 19 87 , to May 1 19 87 , that (X) (we) last saw the deceased alive on May 1 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do) view the body after death.							
22b. SIGNATURE <i>T. Chami</i>					DEGREE		22c. DATE SIGNED 5/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TAWFIK CHAMI					22e. ADDRESS c/o Maryland General Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-5-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				25a. DATE REC'D. BY REGISTRAR MAY 08 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pedersen</i>	

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20/02/2010

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Anna Mae Bowser					2a. DATE OF DEATH MONTH DAY YEAR 5 12 87					2b. HOUR M	
3. SEX Fem		4. RACE Col. 2		5. DATE OF BIRTH MONTH DAY YEAR 1 3 12		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? usa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3600 W. Franklin St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3600 W Franklin St - 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Elisha Lindsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Terry		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218-10-0808		17. INFORMANT ADDRESS housewife - 4209 Colbourne Rd (29)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ATHYROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JUN 18</u> , 19 <u>86</u> , to <u>5/12</u> , 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>5/4</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.											
23a. SIGNATURE John Shauzn				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/15/87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN SHAUZN				22e. ADDRESS LINTHICUM, MD 518 CAMP MARIAN RD 21090							
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 5/16/87		23c. NAME OF CEMETERY OR CREMATORY Ortutus Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Ortutus Mem Pa Md.					
24. FUNERAL DIRECTOR NAME Charles H. Powell				ADDRESS 1206 W. North Ave				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall	

MEDICAL CERTIFICATION

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Handwritten notes in the middle section, including the word "Conclusion" and some illegible text.

Handwritten notes at the bottom of the page, including the word "References" and some illegible text.

055020 JUN 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

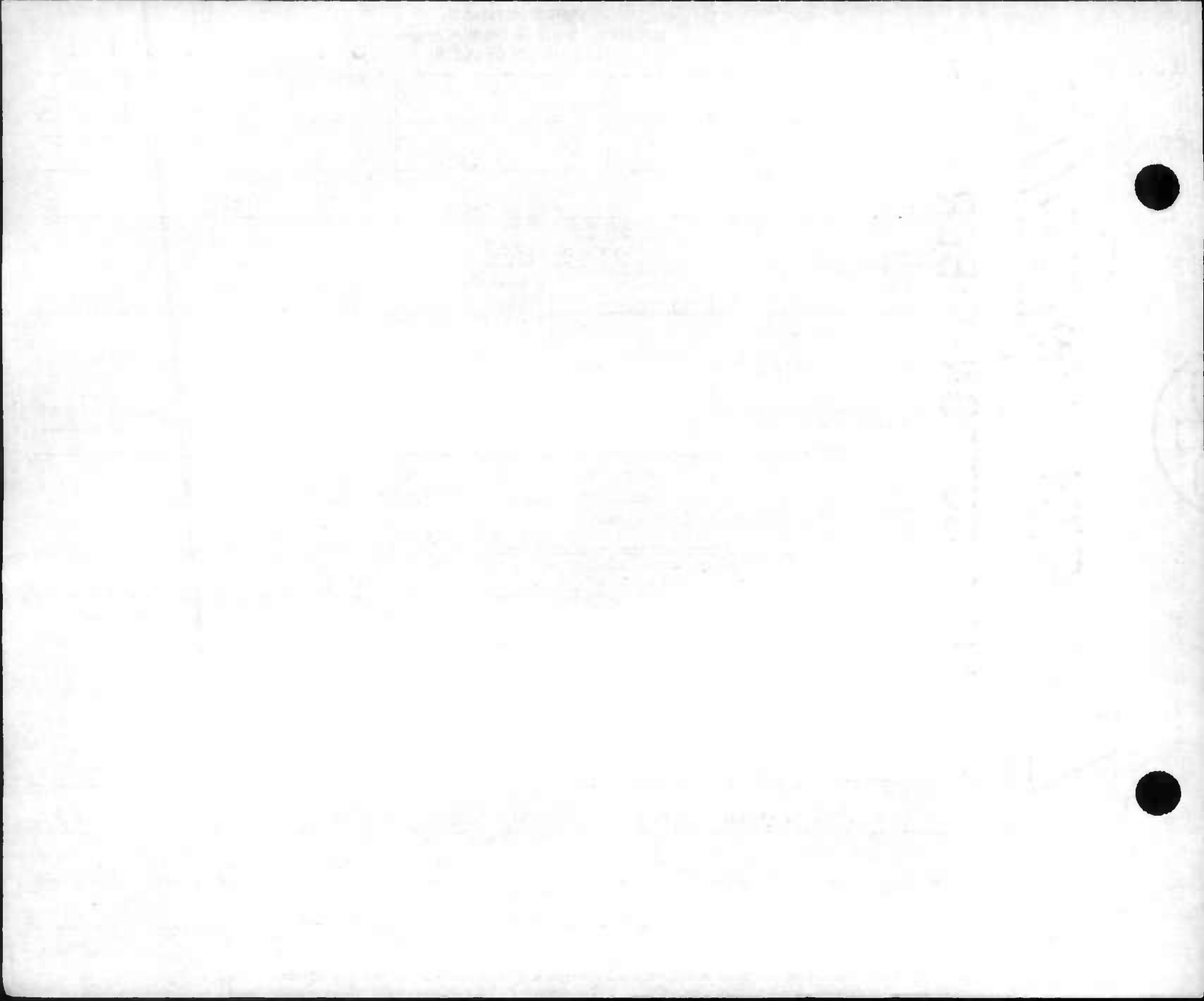
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8713311
REG. NO.FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Annie T. Boyd			2a. DATE OF DEATH MONTH DAY YEAR 5-26-87		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 26 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1002 N. Payson Street 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Tony Tyson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bynum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lawrence Boyd 1002 Payson St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF } (c) Atherosclerotic CVS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal failure, Diabetes, cold, old CVA.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-3 1987 to 4-8 1987, that (I) (we) lost saw the deceased alive on 4-8 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE JAVAD M SHAFI		DEGREE MD		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. J. Shafi		22e. ADDRESS 2300 Garrison Rd 21216			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park	
23d. LOCATION CITY OR TOWN Arbutus		COUNTY Md		STATE	
24. FUNERAL DIRECTOR NAME Wm C March F/H West		ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR JUN 1 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodach			

BP



#10
053595 MAY 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
3. SEX					4. RACE					5. DATE OF BIRTH				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. STATE					13b. COUNTY					13c. CITY OR TOWN				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. SOCIAL SECURITY NO.				
17. INFORMANT					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					19. DATE OF OPERATION				
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION				
21f. LOCATION					22a. I certify that (I) (this hospital) attended the deceased from					22b. SIGNATURE				
22b. SIGNATURE					22c. DATE SIGNED					22d. PHYSICIAN'S NAME (TYPE OR PRINT)				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION					24. FUNERAL DIRECTOR				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Percy					Boyd					05 12 87				
M					B					10 15 15				
VA.					U.S.A.					Baltimore City				
Baltimore City					Singi Hospital					Unemployed				
MD					Baltimore					3016 Wayne Ave 21207				
Jeff					Diny					Hendricks				
NO					217-14-1463					Joanne Mondowney 2014 McEldred St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a)					Cardiorespiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Aspiration pneumonia					24 HRS				
DUE TO, OR AS A CONSEQUENCE OF					(c) Cerebral vascular accident					One month				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:														
Renal failure, Pericarditis														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION				
21f. LOCATION					22a. I certify that (I) (this hospital) attended the deceased from					22b. SIGNATURE				
22b. SIGNATURE					22c. DATE SIGNED					22d. PHYSICIAN'S NAME (TYPE OR PRINT)				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION					24. FUNERAL DIRECTOR				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Entombment					5-18-87					Md. Mary Mem. Park				
March Funeral Home 1101 E. North Ave.					MAY 15 1987					Julia Davidson-Randall				

INFORMATION REPORT
HYDROLOGICAL DATA

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055176 JUN 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, it may be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for medical advice.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Henry E. Boyer</i>									
2a. DATE OF DEATH MONTH DAY YEAR <i>05 30 87</i>		2b. HOUR <i>307 AM</i>							
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>February 28, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ship Fitter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Coast Guard Yd.</i>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>7628 Paradise Beach Rd. 21122</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry M. Boyer</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elsie V. Gardner</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>209 09 0577</i>		17. INFORMANT <i>Margaret I. Boyer</i>		ADDRESS (Same as 13a-e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Large Cell Carcinoma of Left Lung</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Large Cell Carcinoma of Left Lung</i>									
19a. DATE OF OPERATION <i>5/27/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/30/87</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/27/87</i> , 19__, to <i>5/30/87</i> , 19__, that (I) (we) last saw the deceased alive on <i>5/30/87</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dana S. Simpler MD</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>5/30/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANA S SIMPLER MD</i>				22e. ADDRESS <i>MERCY HOSPITAL</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 2, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Anne Arundel MD</i>			
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration. The President states that he is committed to the principles of liberty and justice for all, and that he will work to maintain the Union. He also mentions the issue of slavery, which was a major point of contention at the time.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It provides a detailed account of the financial state of the country. The report mentions the national debt, which had increased significantly since the end of the Civil War. It also discusses the various taxes and duties that were levied on the population, and the ways in which the government was spending the money.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It provides a detailed account of the land and natural resources of the country. The report mentions the various territories that were being explored and developed, and the ways in which the government was managing the land. It also discusses the various minerals and other resources that were being found, and the ways in which they were being used.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1861. It provides a detailed account of the military forces of the country. The report mentions the various regiments and brigades that were being raised, and the ways in which they were being trained. It also discusses the various weapons and equipment that were being used, and the ways in which they were being distributed.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 1, 1861. It provides a detailed account of the naval forces of the country. The report mentions the various ships and vessels that were being built, and the ways in which they were being equipped. It also discusses the various naval bases and ports that were being established, and the ways in which they were being defended.

6. The sixth part of the document is a report from the Secretary of the State, dated January 1, 1861. It provides a detailed account of the foreign relations of the country. The report mentions the various treaties and agreements that were being signed, and the ways in which they were being implemented. It also discusses the various diplomatic missions and consulates that were being established, and the ways in which they were being managed.

7. The seventh part of the document is a report from the Secretary of the Education, dated January 1, 1861. It provides a detailed account of the educational system of the country. The report mentions the various schools and colleges that were being established, and the ways in which they were being funded. It also discusses the various educational reforms that were being implemented, and the ways in which they were being evaluated.

8. The eighth part of the document is a report from the Secretary of the Agriculture, dated January 1, 1861. It provides a detailed account of the agricultural industry of the country. The report mentions the various crops and livestock that were being raised, and the ways in which they were being marketed. It also discusses the various agricultural reforms that were being implemented, and the ways in which they were being evaluated.

9. The ninth part of the document is a report from the Secretary of the Commerce, dated January 1, 1861. It provides a detailed account of the commercial industry of the country. The report mentions the various goods and services that were being produced, and the ways in which they were being transported. It also discusses the various commercial reforms that were being implemented, and the ways in which they were being evaluated.

10. The tenth part of the document is a report from the Secretary of the Finance, dated January 1, 1861. It provides a detailed account of the financial industry of the country. The report mentions the various banks and financial institutions that were being established, and the ways in which they were being regulated. It also discusses the various financial reforms that were being implemented, and the ways in which they were being evaluated.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 1 3 3 1 4
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) STELLA ROSE BRADEN		2a. DATE OF DEATH MONTH DAY YEAR 5 19 87		2b. HOUR 9:40 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Rose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Manos		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212 20 8203	
17. INFORMANT Mr. Gus E. Rose		ADDRESS Sparks, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with METASTASIS TO LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>STAPH. SEPSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/19/87 to 5/19/87, that (I) (we) lost saw the deceased above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Ch. Woreta MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMSACHEW WORETA		22e. ADDRESS NORTH CHARLES HOS PITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/87		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., MD		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Barber	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

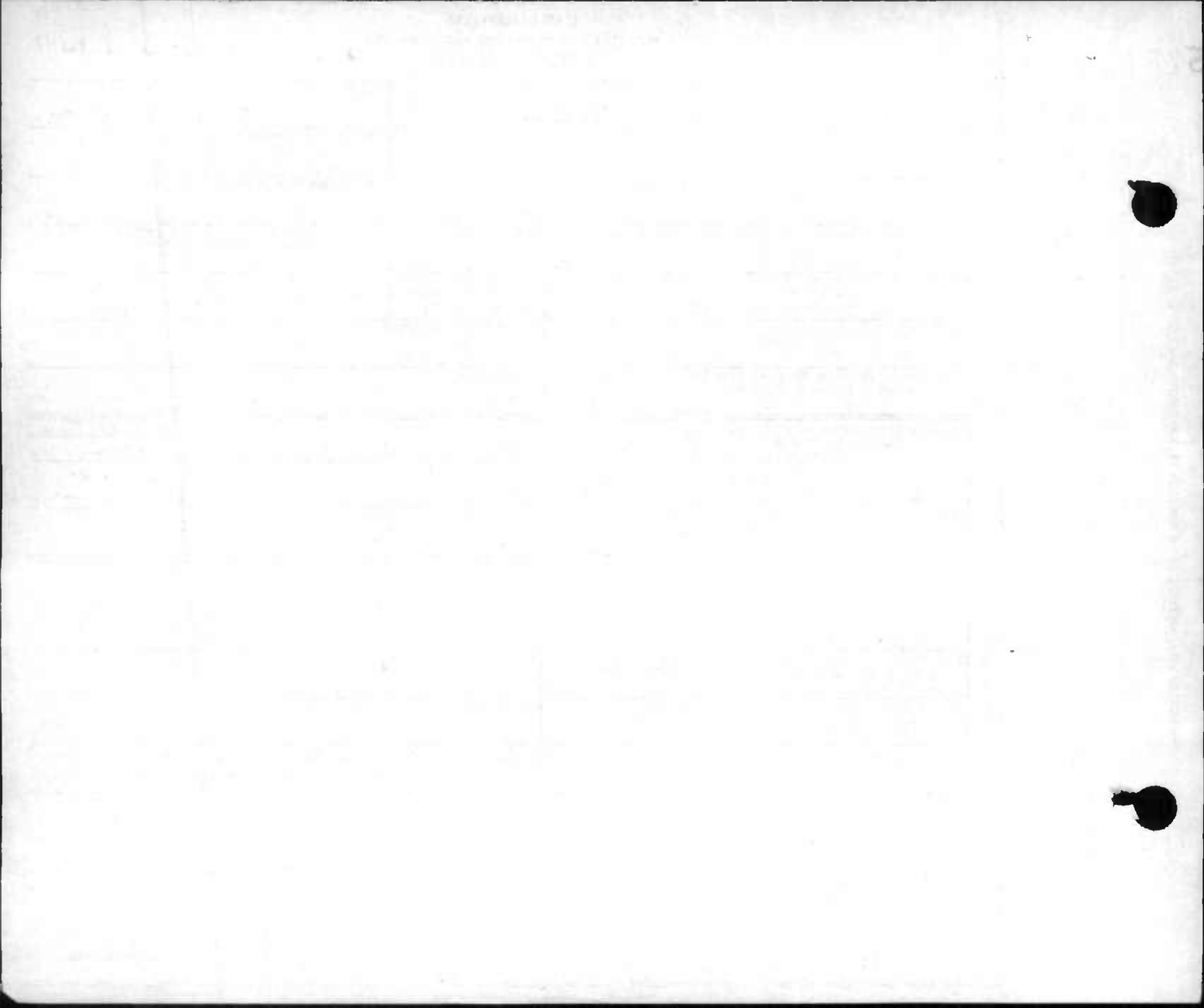
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 1 5

REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8 7 1 3 3 1 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA J BRAXTON			2a. DATE OF DEATH MONTH DAY YEAR 5 4 87		2b. HOUR 0829a.m.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 31 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 819 N. Collington Ave. 21205		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 819 N. Collington Ave. 05
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Dorman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arrisetta Gattis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 215121199		17. INFORMANT ADDRESS Allen Braxton 819 Collington Ave. 05	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Colon CA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Large (4) colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1.6 hr.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION 4/15/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructing Colon Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/12/87, 19 87, to 5/4, 19 87, that (I) (we) last saw the deceased alive on 5/3, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James Atkins</u>		DEGREE		22c. DATE SIGNED 5/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES ATKINS		22e. ADDRESS ST. AGNES HOSPITAL BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/9/87	23c. NAME OF CEMETERY OR CREMATORY Head of Greek		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR MAY 6 1987	25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13316

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA L. BREEDING			2a. DATE OF DEATH MONTH DAY YEAR 5-16-87		2b. HOUR M M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8-1-1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2500 E. FAIRMOUNT AVE. 21224
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS E. HORNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA BREHM.		16. ADDRESS Qwe. 21224 -	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-20-5283		17. INFORMANT Mr. Edward L. Breeding - 2500 E. Fairmount	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Amyotrophic lateral sclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~11 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Hypertension Diabetes mellitus					
19a. DATE OF OPERATION 5/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA 9		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA BALTO, MD.	
22a. I certify that (I) (this hospital) attended the deceased from 3/17/86 to 5/16, 19 87 , that (I) (we) last saw the deceased alive on 4/27 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rosemary Olivo		DEGREE MD		22c. DATE SIGNED 5/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSEMARY OLIVO MD		22e. ADDRESS 5444 BELAIR RD BALTO, MD 21206			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-19-87	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILLS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO, MD.
24. FUNERAL DIRECTOR NAME Valley View - 2334 Jefferson St.			25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

053838

16K

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713311

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD B. BREIVOGEL, Sr			2a. DATE OF DEATH MONTH DAY YEAR 5-15-87			2b. HOUR 0938 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 17 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Service			
13a. STATE Arizona		13b. COUNTY Mesa		13c. CITY OR TOWN Mesa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4639 E. Emerald 85206			
14. FATHER'S NAME FIRST MIDDLE LAST Harry J. Breivogel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche A. Callahan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 218-18-9785		
17. INFORMANT Donald B. Breivogel, Jr.			ADDRESS N.Y. 11783			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE DUE TO, OR AS A CONSEQUENCE OF (b) OCCLUSION CORONARY ARTERIES, LEFT + RIGHT DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) MYOCARDIAL INFARCTION OLD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael E. Pelczar						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR MD						22e. ADDRESS St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/87		23c. NAME OF CEMETERY OR CREMATORY Az. Vet. Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix Maricopa Az.				
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE John Anderson-Randall			

MEDICAL CERTIFICATION

999999

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

132220

053186 MAY 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13318

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Earl BRICE			2a. DATE OF DEATH MONTH DAY YEAR 5 10 87			2b. HOUR 6:30 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 26 27		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBCH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipbuilder		12b. KIND OF BUSINESS OR INDUSTRY Md. Drydock			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 442 N. Patapsco Ave. #201 21225	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE Brice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Perkins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 233109811		17. INFORMANT N. Linthicum, Md. 21090 Judith Wagner 5629 Troquay Reach							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 9 1987, to May 10 1987, that (I/we) last saw the deceased alive on May 10 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE Terry Lamb				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERRY LAMB				22e. ADDRESS 3001 S. BALTIMORE GEN. HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/87		23c. NAME OF CEMETERY OR CREMATORY Arbovale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arbovale Lewisburg, W.		23e. DATE OF BURIAL MAY 11 1987	
24. FUNERAL DIRECTOR NAME Mocully Funeral Homes				237 E. Patapsco Ave., Balto., Md. 21225		25a. DATE OF REGISTRATION MAY 11 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove person-page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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1

MAILED 1985

54671 MAY 28 1987

FOR
- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence Milton Bridges			2a. DATE OF DEATH MONTH DAY YEAR May 23, 87			2b. HOUR 9:35 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bozman, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 803 Union Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Clerk		12b. KIND OF BUSINESS OR INDUSTRY Wholesale Drugs	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 803 Union Avenue 21211	
14. FATHER'S NAME FIRST MIDDLE LAST William Bridges			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Helen C. Bridges		ADDRESS 803 Union Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerosis, Emphysema									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from May 23, 19 87, to May 23, 19 87, that (I) (we) last saw the deceased alive on May 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Vissing					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 24 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Vissing					22e. ADDRESS 4300 N. Charles St #56 Baltimore, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 05 27 87		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll Co., Md.		
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home, Baltimore, Md.					25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Julia F. Brown-Rodgers		

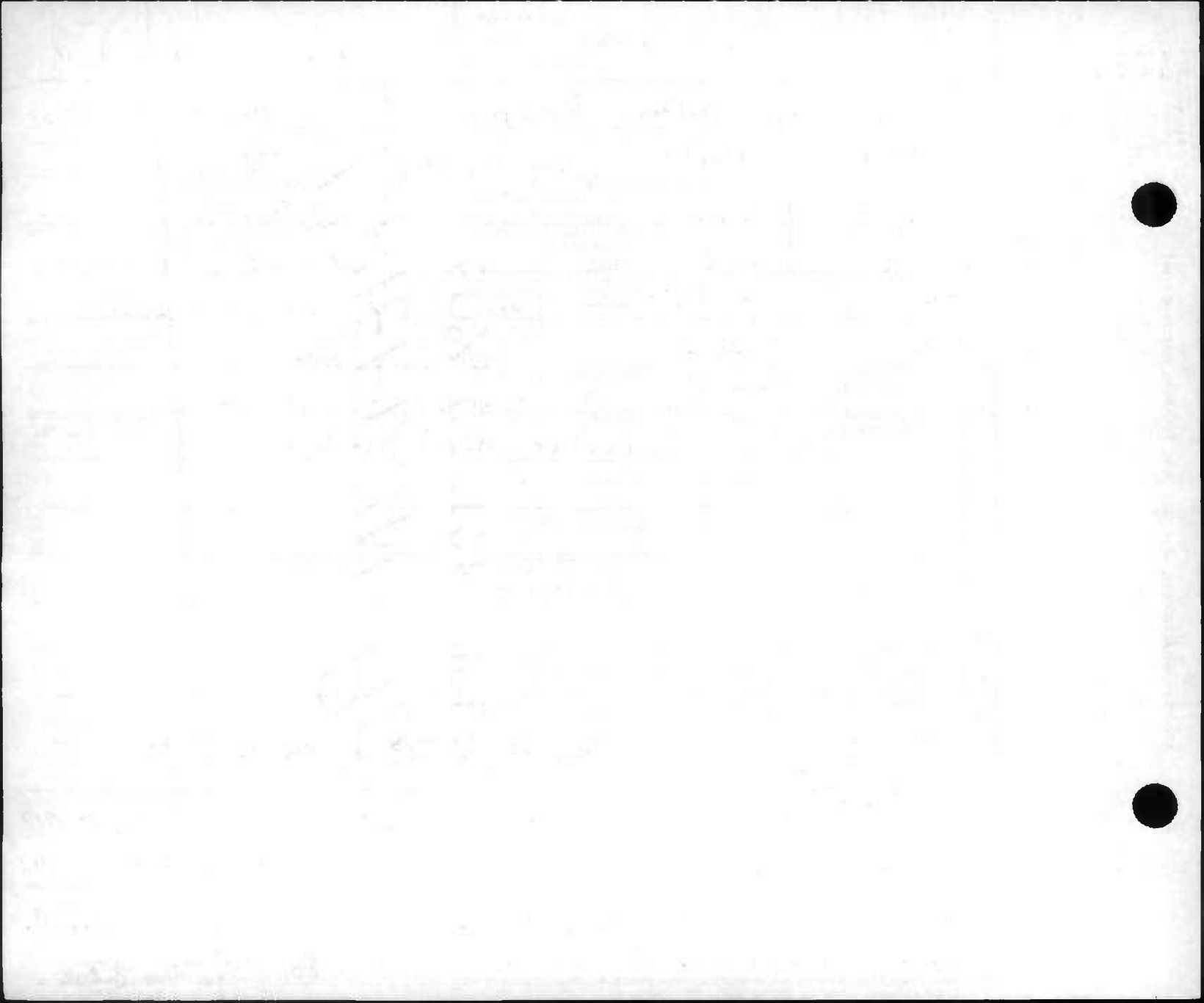
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 check any injury, or other traumatic event, the medical examiner may be required to examine the body.

Burgee-Henss



054208 MAY 21

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

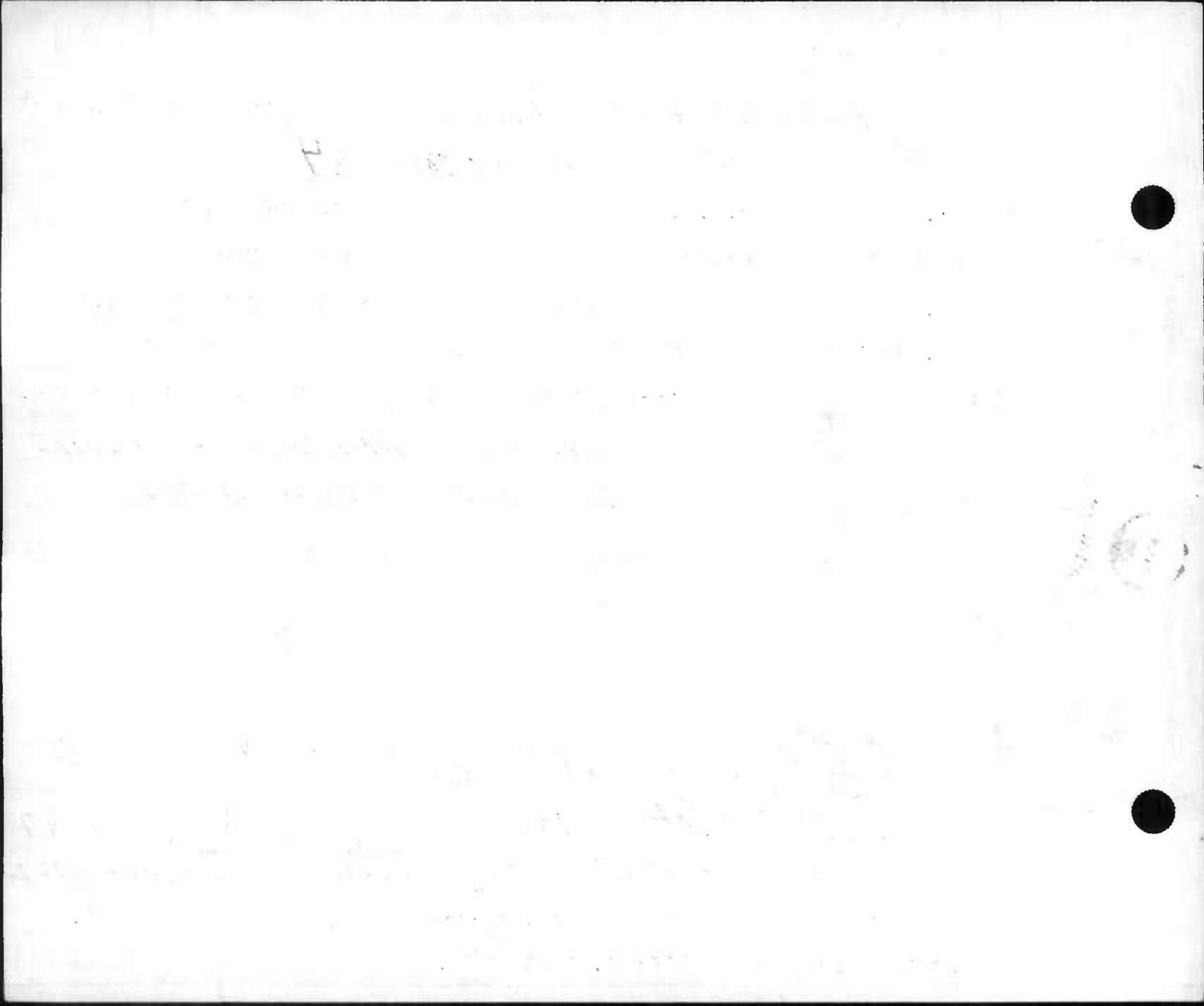
87

13320

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRIETTA E. BROOKS			2a. DATE OF DEATH MONTH DAY YEAR 05-17-87		2b. HOUR MIN. 11:55 A	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 08 25 1902		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 84		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4010 WILSBY AVE. 21218				
14. FATHER'S NAME FIRST MIDDLE LAST REV. ERNEST JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA HOLMES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-14-1664		17. INFORMANT ADDRESS ANNIE MAE STOKES 4010 WILSBY AVE.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CEREBRAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 5-11 , 19 87 , to 5-17 , 19 87 , that (1) (two) lost saw the deceased alive on 5-17 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)						
22b. SIGNATURE C J NESBITT		DEGREE MD		22c. DATE SIGNED 5-17-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C J NESBITT		22e. ADDRESS Mercy Hospital 301 St Paul Ave Balt 21202				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-22-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL		
23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD.		24. FUNERAL DIRECTOR NAME ADDRESS MARCH FUNERAL HOME 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR MAY 19 1987		
				25b. REGISTRAR'S SIGNATURE W. A. Anderson-Randall		

BP



055269 JUN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director must detach for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

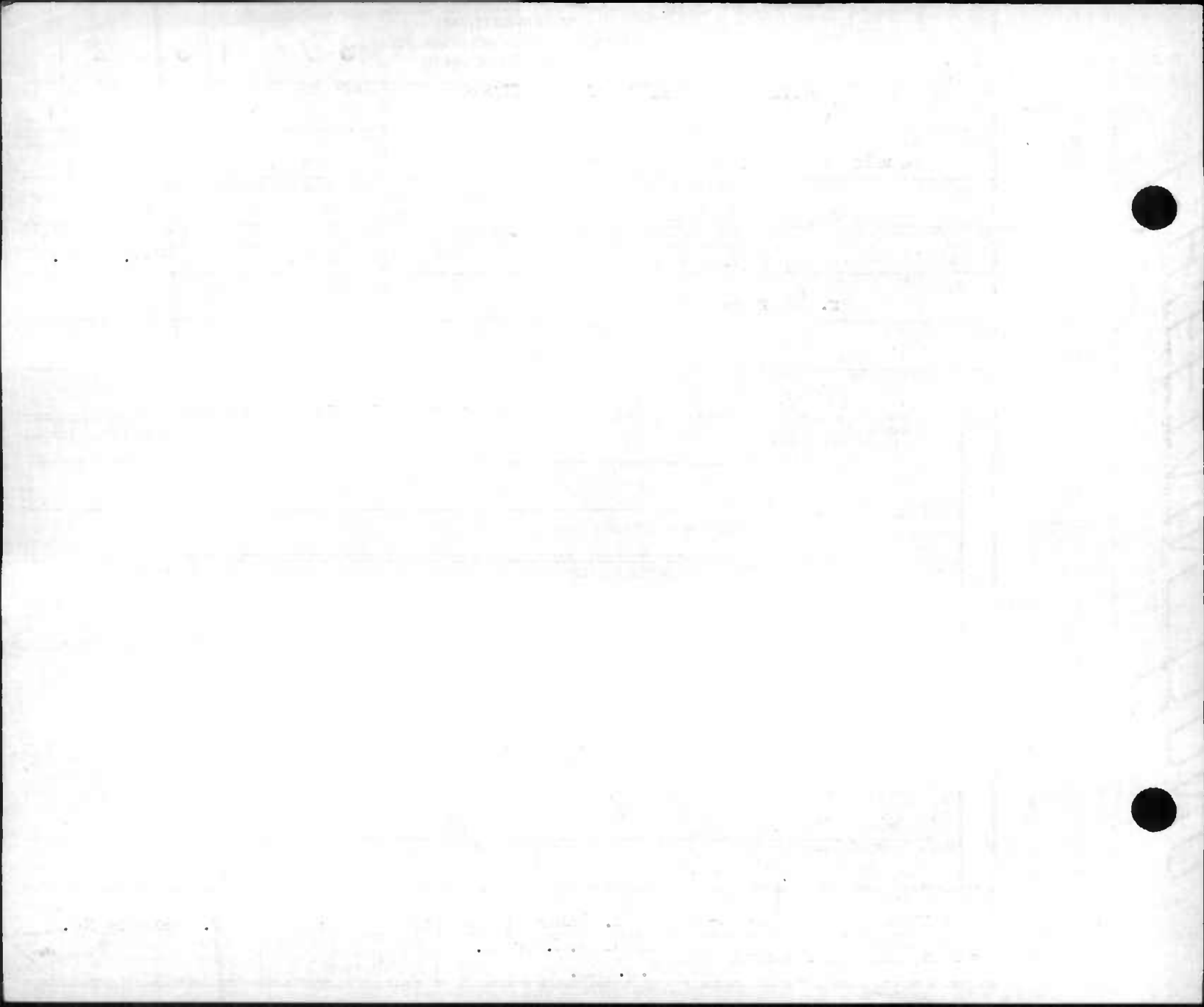
BP

DHMH - 16 60M 7/84
(VIA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13321

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>RITA</u> MIDDLE <u>ELIZABETH</u> LAST <u>BROOKS</u>		2a. DATE OF DEATH MONTH <u>5</u> DAY <u>27</u> YEAR <u>87</u>		2b. HOUR <u>1201A</u> M	
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH <u>7</u> DAY <u>10</u> YEAR <u>27</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington D.C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore city</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Govt.</u>
13a. STATE <u>Md</u>		13b. COUNTY <u>Pr. Georges</u>	13c. CITY OR TOWN <u>Mt. Ranier</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Lewis</u> LAST <u>Lewis</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Downey</u>		13e. STREET ADDRESS / ZIP CODE <u>3515 Ohs St. 20712</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>unknown</u>		16b. SOCIAL SECURITY NO. <u>579289468</u>		17. INFORMANT <u>Gerald Lewis-son-(same as 13e)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 27</u> , 19 <u>87</u> , to <u>May 27</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George V. Acovado</u>		22e. ADDRESS <u>3001 S. Hanover St. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-30-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Pr. Georges Md.</u>		24. FUNERAL DIRECTOR <u>Hines/Rinaldi Funeral Home</u> ADDRESS <u>11800 N.H. Av e. S.S. Md.</u>			
25a. DATE REC'D. BY REGISTRAR <u>JUN 2 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

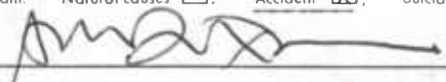



053255

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REALIZE THAT THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH IS REQUIRED FOR THE BURIAL PERMIT. IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

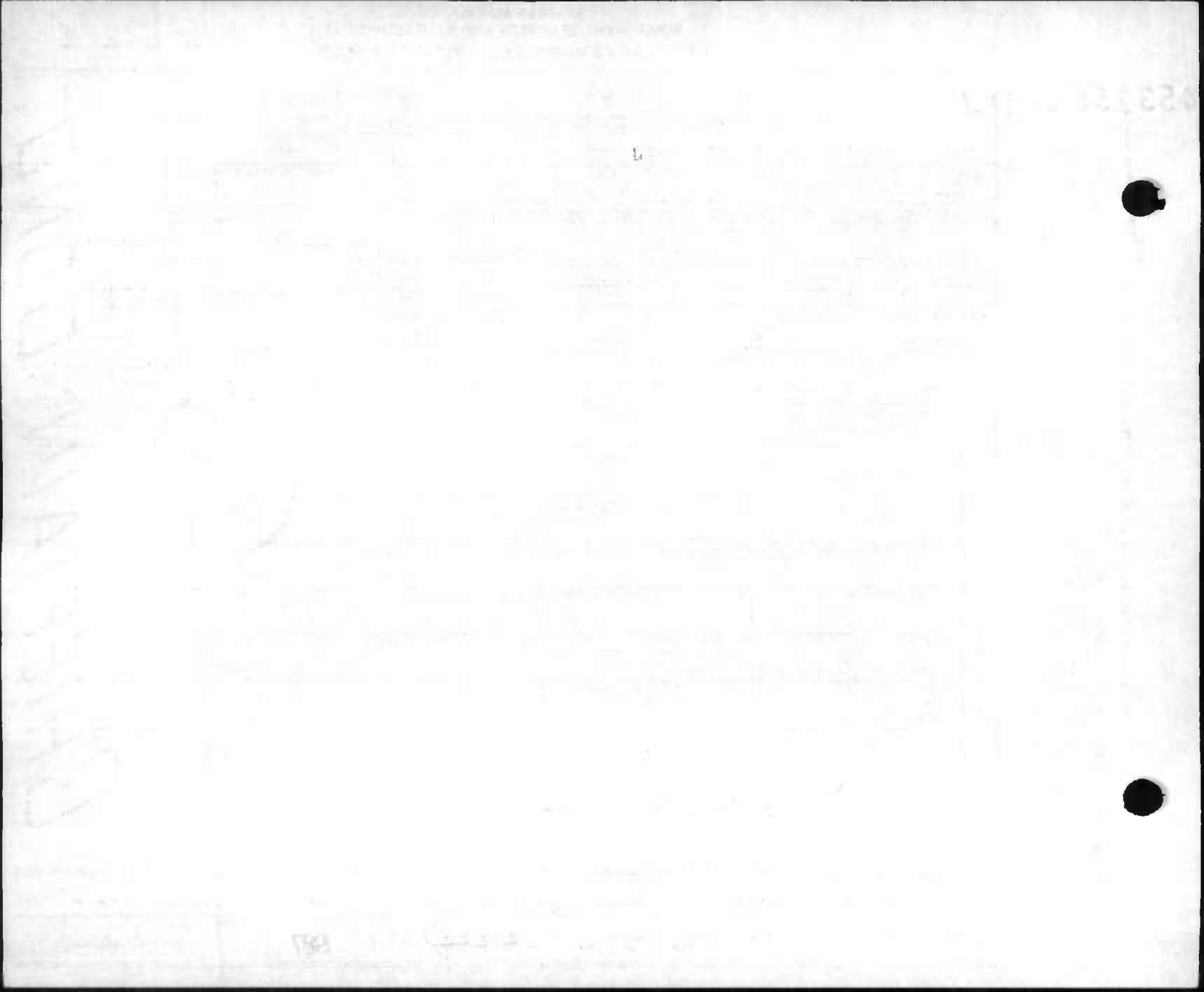
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13322			
1- FOR STATE REGISTRAR										2a DATE KNOWN OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MATTHEW Edward BROUGH										MONTH DAY YEAR 5 8 1987		M A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH (MONTH DAY YEAR) 7 21 1964		6 AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD 5 8 1987		2d HOUR 2:08 A M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Apprentice		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a STATE Maryland				13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6220 Northwood Dr./21212			
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Brough						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis A. Cody							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 412/35/4857		17. INFORMANT ADDRESS Alfred N. Cody 10 Lanciano Irvine, Calif. 92720							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Thoracic trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50xx 5-8- 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/fixed object impact.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION CITY OR TOWN COUNTY STATE Walker Ave. east of Holly Lane, Baltimore County MD							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 5-8-87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/9/1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21202			
24 FUNERAL DIRECTOR Walter Brooks Bradley, Inc. Balto., Md.						25a. DATE REC'D. BY REGISTRAR MAY 11 1987				25b. REGISTRAR'S SIGNATURE 			

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 1 3 3 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
AUBREY L. BROWN				5/ 5 8 87		7.15 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Black	11 30 49		37 YRS		5 8		7 00.15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.C.	USA			Baltimore city MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Liberty Medical Center		Unemployed						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1642 Braddish Ave		21216	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Cleophaus NewKirk		Fannie Isler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		216-50-0795		Fannie Guy 1642 Braddish Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a)		massive Gastrointestinal bleeding							
8552									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Esophageal Varices							
DUE TO, OR AS A CONSEQUENCE OF		(c) Liver Cirrhosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Cocaine over dose									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/11/1987 to 5/8/1987, that (I) (we) first saw the deceased alive on 5/8/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Z.N. Lahiji						5/8/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Z. N. LAHIJI		Liberty Medical Center							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		5/15/87		Parrott Cemetery		Lenor		Co N.C.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H West 4300 Wabash Avenue				MAY 13 1987		Julia Davidson-Randall			

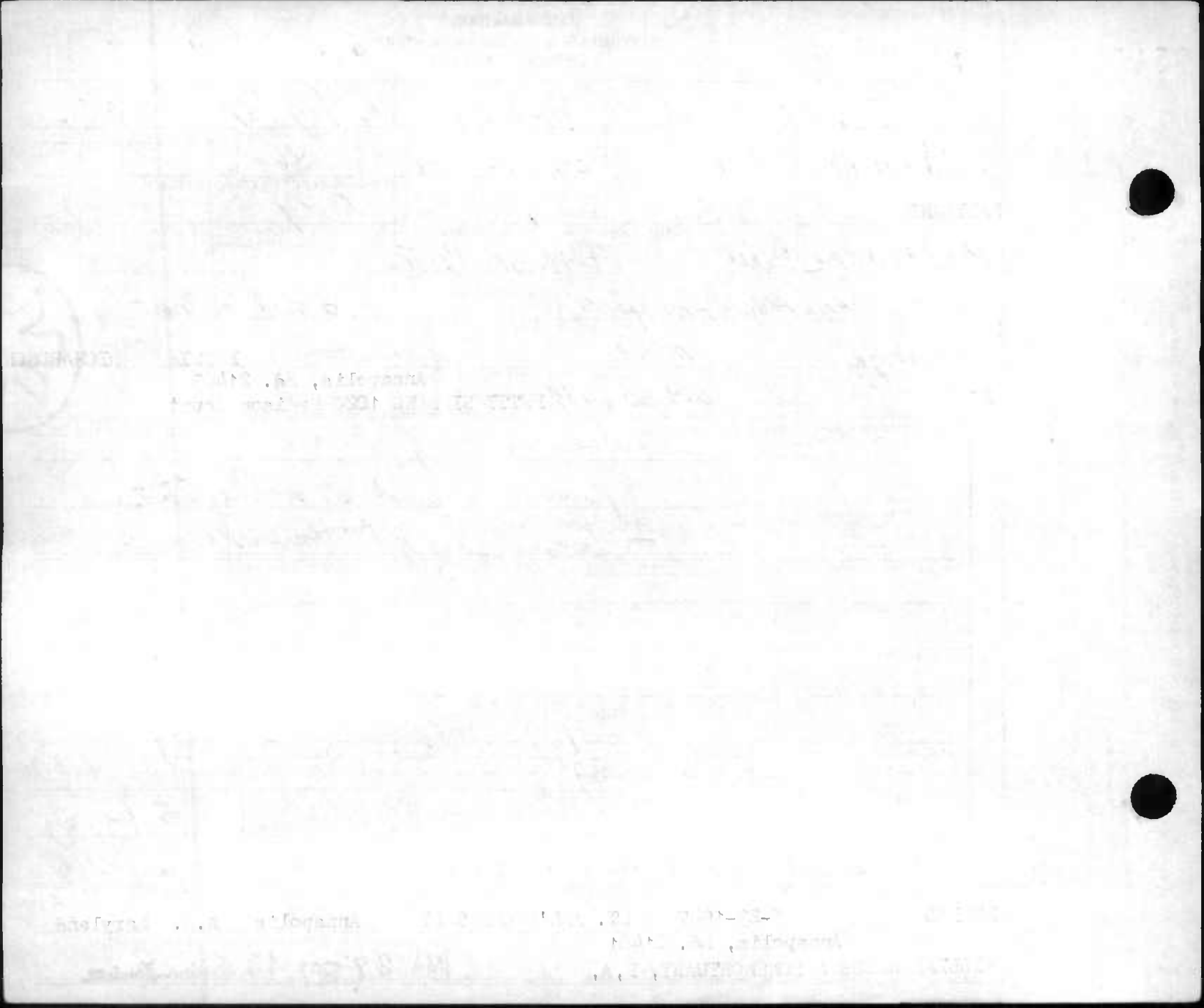
11/11/2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (s). Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 7 1 3 3 2 4			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Edna M. BROWN				05/19/87			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		BLACK		02 05 01		86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.				Cty	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Dorchester Hospital & Medical Center					
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE			
md.		Annapolis		1020 Madison Court		21403	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
George Miller		unknown		219-30-6499		BESSIE RICHARDSON	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. DATE OF OPERATION		18d. CONDITION FOR WHICH OPERATION WAS PERFORMED	
NO		219-30-6499					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) - Cardiac arrest.							
DUE TO, OR AS A CONSEQUENCE OF (b) - Probable Cardiac arrest.							
DUE TO, OR AS A CONSEQUENCE OF (c) - Generalized Arteriosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/19 1987 to 5/19 1987; that (I) (we) lost							
saw the deceased alive on 5/13 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
KUBEN REIDER MD						5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE	
		7445 FURNACE BRANCH Rd Glen		BURIAL		5-23-1987	
24. FUNERAL DIRECTOR		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25a. DATE REC'D. BY REGISTRAR	
Annapolis, Md. 21401		ST. ANN'S CEMETERY		Annapolis A.A. Maryland		25b. REGISTRAR'S SIGNATURE	
WILLIAM REESE & SON MORTUARY, P.A.						MAY 27 1987	



053830

corrected per funeral home

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank		MIDDLE J. O.		LAST Brown		2a. DATE OF DEATH MONTH 5 DAY 6 YEAR 87		2b. HOUR 10¹⁰ P.M.	
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH 4 DAY 18 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS 77 DAYS 77 HOURS 77 MIN. 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY MILFORD STITCH	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE		13b. COUNTY KENT		13c. CITY OR TOWN MILFORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 207 N.W. 5TH STREET/19963	
FATHER'S NAME FIRST FRANK MIDDLE BROWN, SR. LAST BROWN				15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE E. LAST BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 222-03-5773		17. INFORMANT ADDRESS VERIE ROBINSON 207 N.W. 5TH ST., MILFORD, DE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Larynx DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yrs DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 25, 1987 , to May 6, 1987 , that (I) (we) lost saw the deceased alive on May 6, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wanda Wick Davis				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED May 7, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WANDA WICKS-DAVIS				22e. ADDRESS DEATON MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 11, 1987		23c. NAME OF CEMETERY OR CREMATORY SILOAM		23d. LOCATION CITY OR TOWN COUNTY STATE LINCOLN SUSSEX DE			
24. FUNERAL DIRECTOR NAME Clarence E. Joubert ADDRESS 526 UNION ST, MILTON, DE				25a. DATE REC'D. BY REGISTRAR MAY 13 1987		25b. REGISTRAR'S SIGNATURE Julia S. Sanders-Rudner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22830

Handwritten notes and signatures, including a large signature in the center and various smaller markings and text throughout the page.

054804 MAY 2

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH1 3 3 2 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR				
HATTIE FLORENCE BROWN						MONTH DAY YEAR 5 22 19 87			M				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR				
FEMALE	BLACK	MONTH DAY YEAR 1 31 49	LAST BIRTHDAY 38 YRS.	MONTHS DAYS	HOURS MIN.	MONTH DAY YEAR 5 22 19 87			8:15 P M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
NC		USA				Baltimore City			MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Maryland General Hospital				NURSING AID							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		513 Gold St. 21217				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST Arthur Brown			FIRST MIDDLE LAST Hattie Alston										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No			216-50-0439		Marie Glover			1817 Lauretta Ave.			21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						HEAD & ABD. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
						Head & Abd.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED							
			M.D. Deputy Chief			MEDICAL EXAMINER			5-23-87				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS										
Ann M. Dixon, M.D.			111 Penn St., Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			5/29/87		Mt. Zion		Landsdown, Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Wm. C. March F/H 1101 E. North Ave.						MAY 27 1987							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (15))

11-15-50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

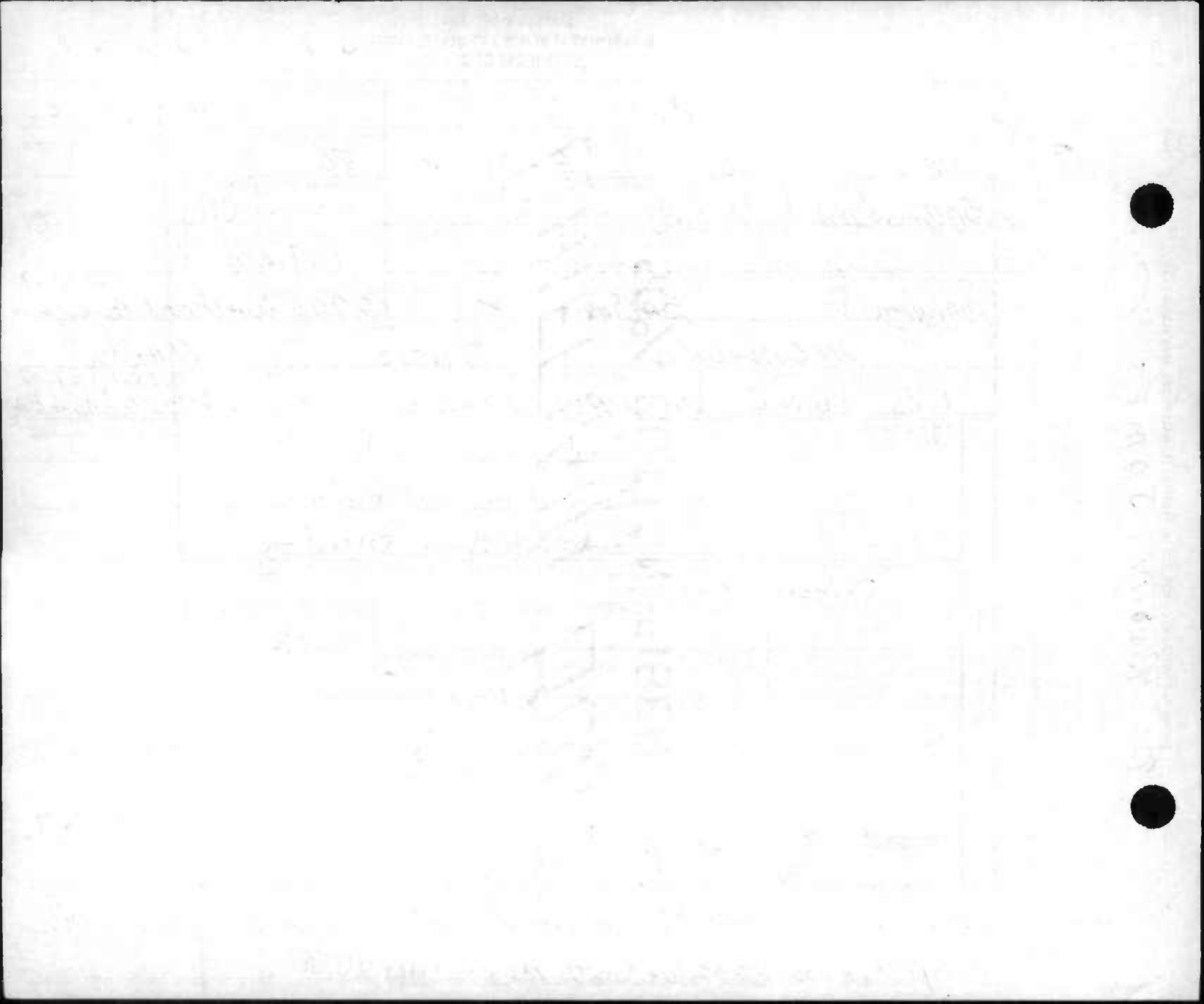
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James R. Brown			2a. DATE OF DEATH MONTH DAY YEAR 5 19 87			2b. HOUR 5:25A M	
3. SEX male		4. RACE Col.		5. DATE OF BIRTH MONTH DAY YEAR 3-29-07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) UNKNOWN		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Susie HARDY		13e. STREET ADDRESS - ZIP CODE 2725 Walbrook Ave. #511		2127	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 215-22-1959		17. INFORMANT Mrs. Bessie Lou Brown		ADDRESS 2725 Walbrook Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal Bleeding</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —		21g. DATE SIGNED 5/19/87	
22a. I certify that (a) this hospital attended the deceased from 5/14/87 to 5/19/87, that (b) we last saw the deceased alive on 5/19/87, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (b) (we) did not view the body after death.							
22b. SIGNATURE Steven J. Crawford				DEGREE M.D.		22c. DATE SIGNED 5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Crawford, M.D.				22e. ADDRESS The Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Mt. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 20 1987	
				25b. REGISTRAR'S SIGNATURE J. Davidson-Russell			

 054094 MAY 21 1987
 2
 922 BROWN, JAMES



053154 MAY 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return page 2 to the State Dept. of Health and Mental Hygiene within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

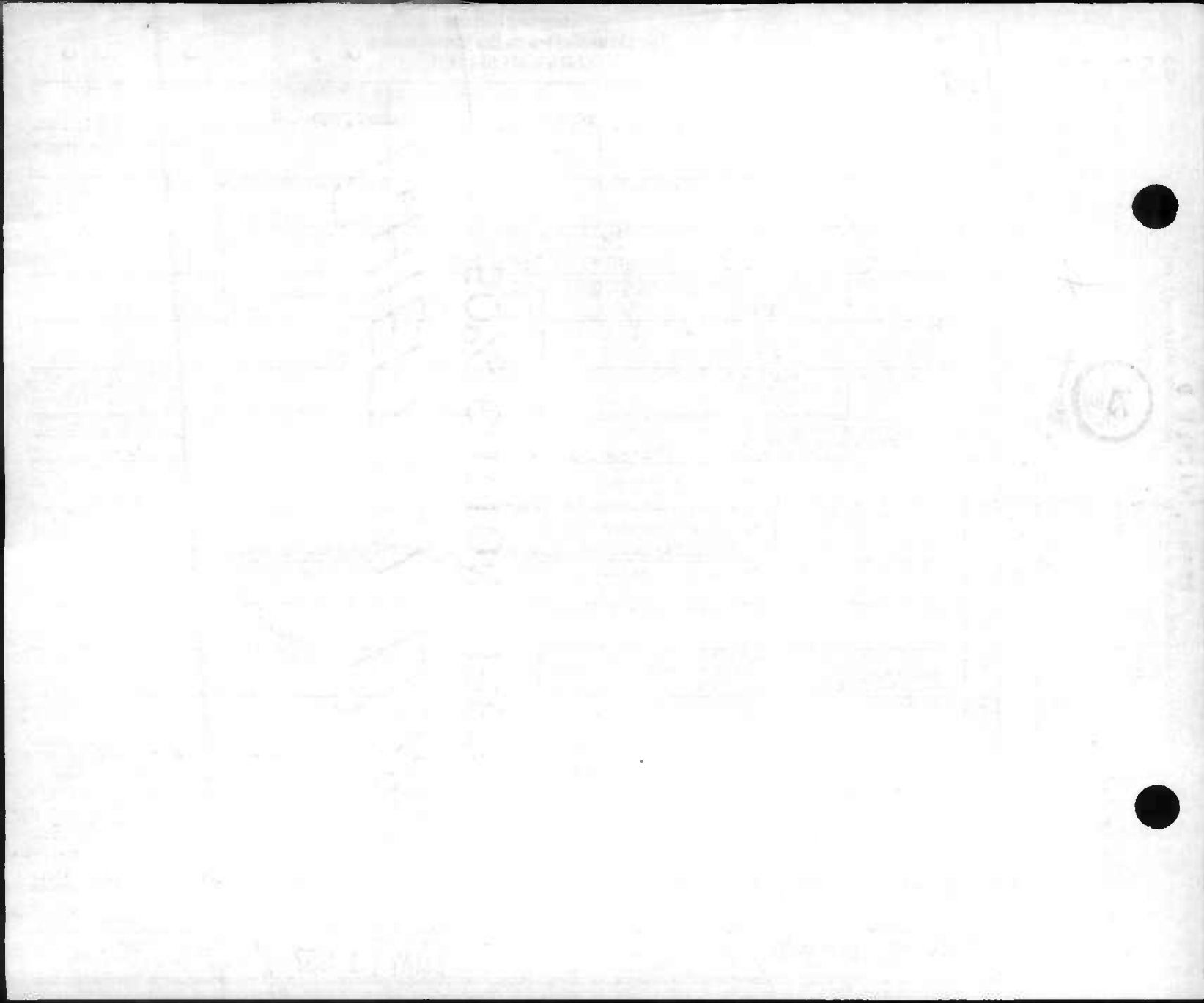
8 7 1 3 3 2 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MICOLE D. BROWN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 29, 1987		2b. HOUR 6:00AM	
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH DAY YEAR DEC. 4, 1982		6. AGE (IN YEARS LAST BIRTHDAY) 4 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE MARYLAND		13b. COUNTY FREDERICK	13c. CITY OR TOWN FREDERICK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE GEORGE BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLORIA CONSTANCE POSTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS WILLIE G. BROWN FREDERICK, MD. 21701		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Acute nonlymphoblastic leukemia in relapse</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 day</u> <u>1 wk</u> <u>2 yr 9 mo</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (u) (his hospital) attended the deceased from <u>APRIL 24</u> , 19 <u>87</u> , to <u>APRIL 29</u> , 19 <u>87</u> , that (u) (we) last saw the deceased alive on <u>APRIL 29</u> , 19 <u>87</u> , and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Barbara Yuse Felt MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/29/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARBARA YUSE FELT MD</u>				22e. ADDRESS <u>DEPT PEDIATRICS JOHNS HOPKINS HOSPITAL BALTIMORE MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>4/30/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SMITHSBURG CREMATORY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SMITHSBURG, WASHINGTON, MD.</u>
24. FUNERAL DIRECTOR <u>R.E. DAILEY & SON, P.A.</u>		ADDRESS <u>1201 N. MARKET FREDERICK, MD. 21701</u>		25. DATE REC'D BY REGISTRAR <u>MAY 11 1987</u>		
26. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>						

BP



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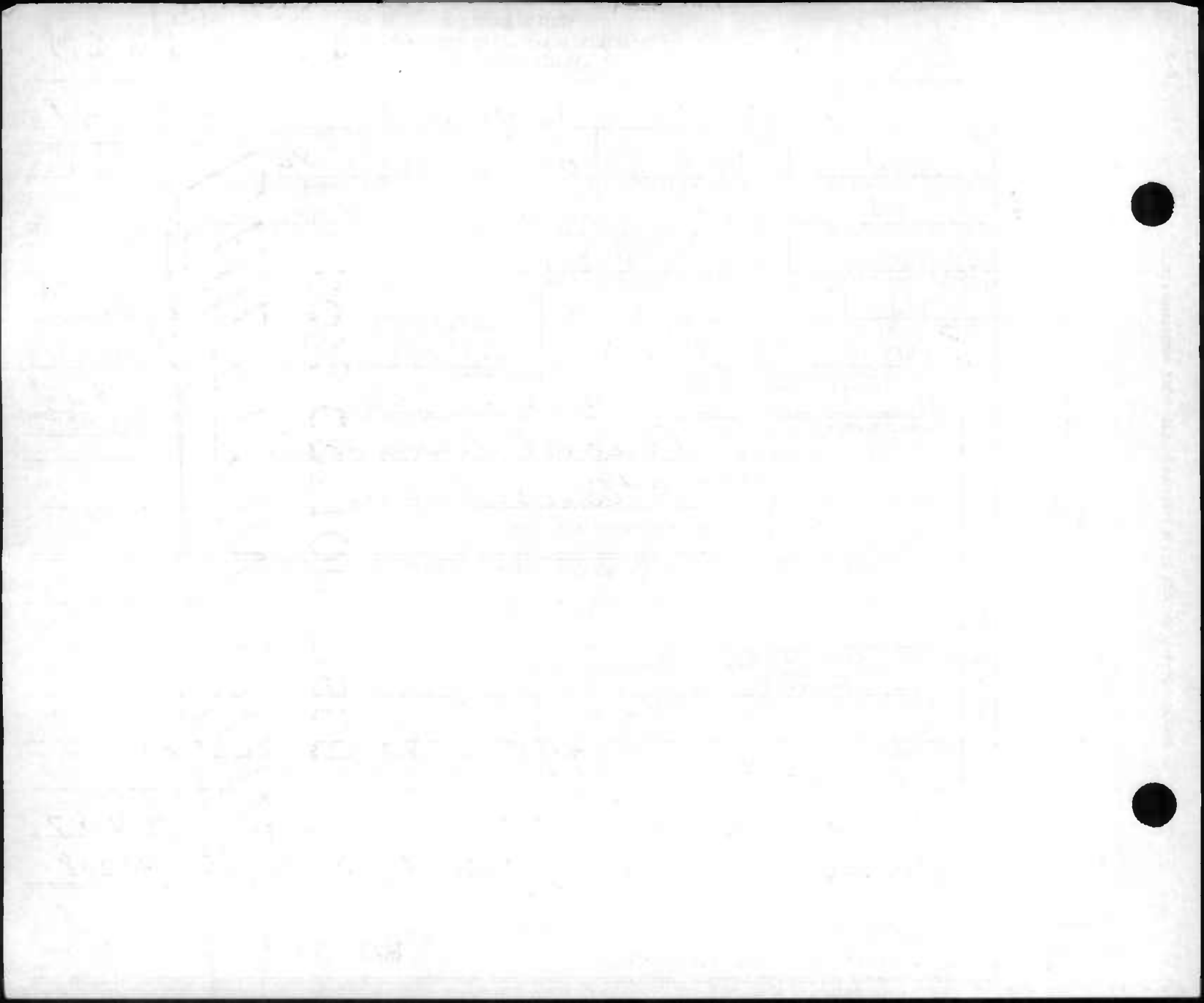
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified, advised.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 2 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Sarah M. Brown		5 2 87		4 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	Black	MONTH DAY YEAR		80 YRS.	
		09 12 1906			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md	USA			Baltimore city MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Villa St Michael		Retired		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md			Baltimore	2004 McKean Ave 21219	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Thomas Cornish		Carrie Hawkkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-03-7300		Regina G. James	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).		Cerebral Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Atherosclerosis			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-15, 19 87, to 5-2, 19 87, that (I) (we) last saw the deceased alive on 4-20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
Harold B. Bob		MD		5-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Harold B. Bob		7220 Park Height		21208	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		5/7/87	Arbutus Mem Park		Arbutus MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H West 4300 Wabash Avenue		MAY 5 1987		Julia Benson-Randall	



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BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR		Joseph Benjamin Bryant Sr.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Joseph Benjamin Bryant Sr.								5 28 87	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		WHITE		7 11 22		64 YRS.		1230 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
SC		U.S.A.				Balto city		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK - MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto City		St Agnes Hospital		Brakeman		Rail Road			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md.		= = =		Baltimore				2819 Maisel St. Balto Md 21230	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
=====		Bryant		=====		251-26-3001		Mary V. Bryant Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c)		19. DUE TO, OR AS A CONSEQUENCE OF		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Squamous cell ca of lung									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/8 19 87 to 5/28 19 87, that (I) (we) last saw the deceased alive on 5/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
ALVIN S. MADARANG		MD		5/28/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE			
ALVIN S. MADARANG		900 Eaton Ave Baltimore, MD 21229		5/28/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/30/87		Cedar Hill Cemetery		Baltimore A.A. Md			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George J. Gonc		JUN 2 1987							

ALVA
BUTLER
- 10 -

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 7 1 3 3 3 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wallace Bryant			2a. DATE OF DEATH MONTH DAY YEAR 5 27 87		2b. HOUR 10:40 AM		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 - 22 - 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALIT. County - City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SLATER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN		16. STREET ADDRESS / ZIP CODE 5736 RIDGEDALE RD. 21209			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 577-09-7321		17. INFORMANT HELEN BRYANT		ADDRESS 5736 RIDGEDALE RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drug overdoses (digoxin, elavil, tylox) DUE TO, OR AS A CONSEQUENCE OF (c) 8583						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Tongue + Neck Carcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/26 19 87 , to 5/27 19 87 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 5/27 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (I) did not view the body after death.							
22b. SIGNATURE Natalie Brookins-Reddix						22c. DATE SIGNED 5/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Natalie Brookins-Reddix MD						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY Westview Cren.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME Donald Dellea				ADDRESS 322 S. 14th St.		25a. DATE REC'D. BY REGISTRAR JUN 10 1987	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

[illegible]

055059 JUN-20

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 3 3 3 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Naomi L Buck</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5 26 87</u>		2b. HOUR <u>2:15 A.M.</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>4 08 14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Scott Key Medical Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Dundalk</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>1833 Portship Road 21222</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Otto Schmiedicke</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Henrietta Steinbach</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. <u>212-46-4165</u>	17. INFORMANT ADDRESS <u>Clarence E. Buck Same as 13e.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 d</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 25</u> , 19 <u>87</u> , to <u>Aug 26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Aug 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>P. Keiser MD</u>		DEGREE		22c. DATE SIGNED <u>5/26/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KEISER</u>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>5-29-87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck Funeral Home of Dundalk</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 1 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ESTHER V. BUCKHEIT			2a. DATE OF DEATH MONTH DAY YEAR 5 10 87			2b. HOUR 10:32a	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 14 1916	6. AGE (IN YEARS LAST BIRTHDAY) YRS 70		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman.		12b. KIND OF BUSINESS OR INDUSTRY Epstein's		

13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6100 Cardiff Ave. 21224
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14. FATHER'S NAME FIRST MIDDLE LAST Claude Miles	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Clark
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-9218	17. INFORMANT ADDRESS Fred Buckheit 6100 Cardiff Ave. 21224
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car</u> CARDIOGENIC SHOCK		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from May 9, 1987, to May 10, 1987, that (I) (we) lost saw the deceased alive on May 10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
--

22b. SIGNATURE Adel S. El-Hennawy	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adel S. EL-Hennawy	22e. ADDRESS CHH.
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23a. BURIAL, CREMATION, REMOVAL (SPE"IFY) Cremation	23b. DATE 5/11/87	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
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24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc.	ADDRESS 1901 Eastern Ave. 21231	25a. DATE REC'D BY REGISTRAR MAY 12 1987	25b. REGISTRAR'S SIGNATURE
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Bullock			2a. DATE OF DEATH MONTH DAY YEAR May 2 1987		2b. HOUR 2:35 AM						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1/1/87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 81		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 2 YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1701 Eutaw Pl 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Ed Bullock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Bullock								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 246-18-0180			17. INFORMANT ADDRESS Geneva Bullock 301 McMechen St			Apt. 707 21217		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD; Pulmonary Emboli											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 39 April 1987 to 2 May 1987 , that (I) (we) lost saw the deceased alive on 2 May 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David A. Jung						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 May 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/8/87		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilson N.C.				
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA						ADDRESS 1300 Eutaw place		25a. DATE REC'D. BY REGISTRAR MAY 7 - 1987			
25b. REGISTRAR'S SIGNATURE John Davidson-Randall											

MEDICAL CERTIFICATION

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

18
The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors of the City of New York, for the year 1900.

1900
The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors of the City of New York, for the year 1900.

53312 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 87-13335			
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FRANK C BURGESS										2a. DATE KNOWN OF DEATH		2b. HOUR	
3 SEX M 4. RACE W 5. DATE OF BIRTH 6 19 12 74 6. AGE (IN YEARS) 74 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. 9. BALTIMORE CITY OR COUNTY OF DEATH										2a. DATE KNOWN OF DEATH		2b. HOUR	
7a. BIRTHPLACE S.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED NEVER MARRIED WIDOWED DIVORCED										2a. DATE KNOWN OF DEATH		2b. HOUR	
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 11 W. 20th Street Apt. 4N 12a. USUAL OCCUPATION DAIRY WORK 12b. KIND OF BUSINESS OR INDUSTRY DAIRY										2a. DATE KNOWN OF DEATH		2b. HOUR	
13a. STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS 11W.20TH. ST.APT.4										2a. DATE KNOWN OF DEATH		2b. HOUR	
14. FATHER'S NAME GEORGE BURGESS 15. MOTHER'S MAIDEN NAME MARY BRITT										2a. DATE KNOWN OF DEATH		2b. HOUR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS STUHR F.H. CHARLESTON S.C.										2a. DATE KNOWN OF DEATH		2b. HOUR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes mellitus													
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above; held on death resulted from Natural causes Accident Suicide Homicide Undetermined manner Autopsy Inspection Inquiry and in my opinion													
ACTUAL SIGNATURE John E. Smialek, M.D. TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 5-2-87													
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal 23b. DATE 5/11/87 23c. NAME OF CEMETERY OR CREMATORY BETHANY CEM. 23d. LOCATION CITY OR TOWN COUNTY STATE CHARLESTON S.C.													
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 25a. DATE REC'D BY REGISTRAR 5/8/87 25b. REGISTRAR'S SIGNATURE													
4905 York Road Balto., MD 21212													

07/84
25AMBP
DHMH - 17
(VR A15 ME (5))

1911

U.S.

U.S. DEPT. OF AGRICULTURE

WASHINGTON, D.C.

OFFICE OF THE SECRETARY

UNITED STATES OF AMERICA

RECEIVED
JAN 10 1911



Handwritten signature

U.S. DEPT. OF AGRICULTURE

WASHINGTON, D.C.

1911

RECEIVED
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053623 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

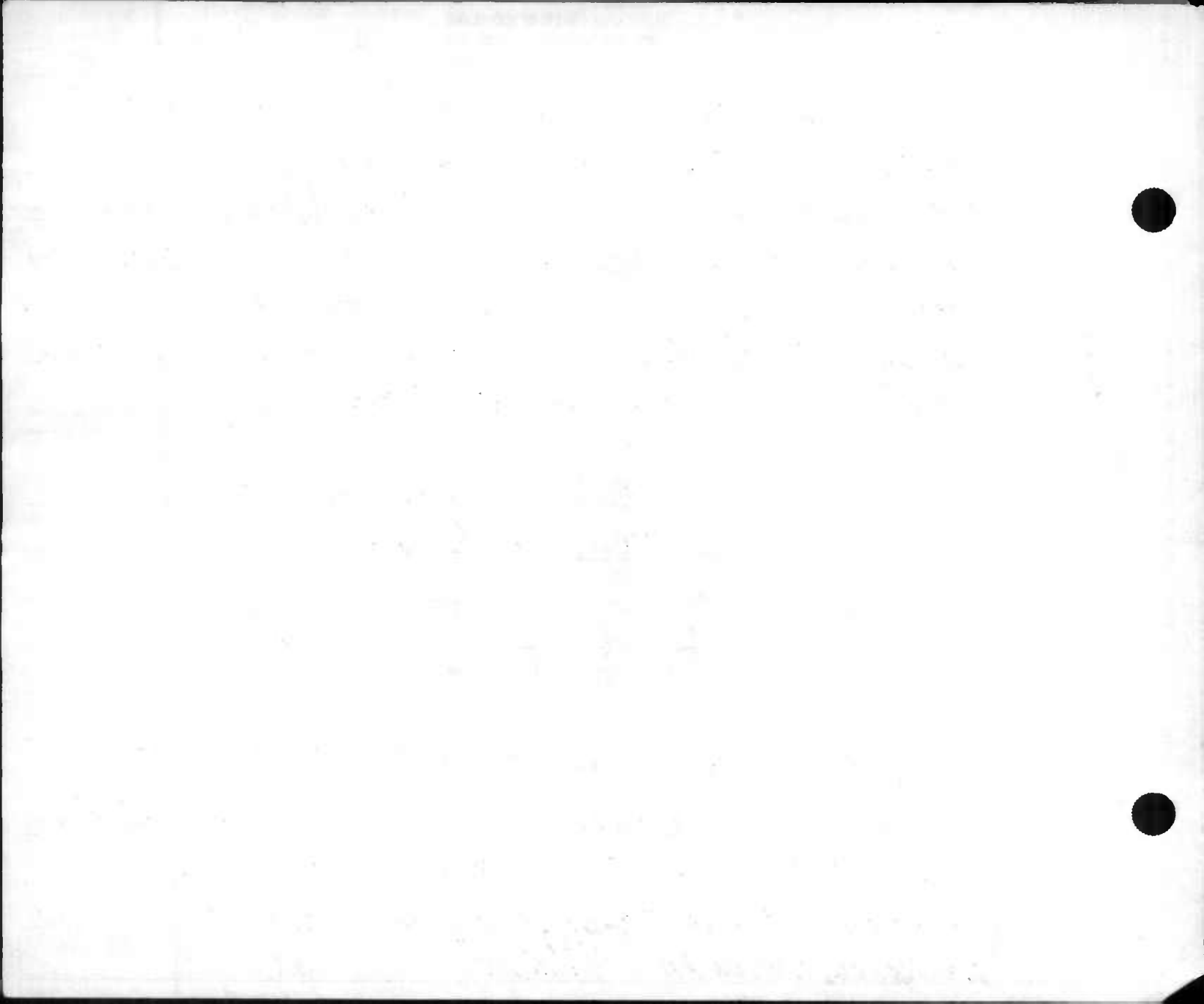
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 3 3 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William J. Burleson Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-12-87</i>		2b. HOUR M <i>M</i>
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4-8-48</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>39</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Washington D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, Maryland</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Grocery Store</i>
13a. STATE <i>Md.</i>	13b. COUNTY <i>Lt. Balt.</i>	13c. CITY OR TOWN <i>Md.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Rt # 2 Box 2086 LaMata Md. 20640</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William J. Burleson Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clitia Thornton Burleson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-62-4946</i>		17. INFORMANT ADDRESS <i>Clitia J. Burleson</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Decubitus ulcers - infected</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Multiple Sclerosis</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> 19 <i>87</i> to <i>5/12</i> 19 <i>87</i> that (I) (we) lost saw the deceased alive on <i>5/12</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dana S. Simplek</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/12/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANA S SIMPLEK</i>		22e. ADDRESS <i>MERCY HOSPITAL</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>May 16-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Zion Bapt. Church Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hilltop Charles Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Montgomery Brothers F.N.</i>		ADDRESS <i>719 Kennedy St. Wash. D.C.</i>		25. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>	

DATE REC'D. BY REGISTRAR
MAY 15 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

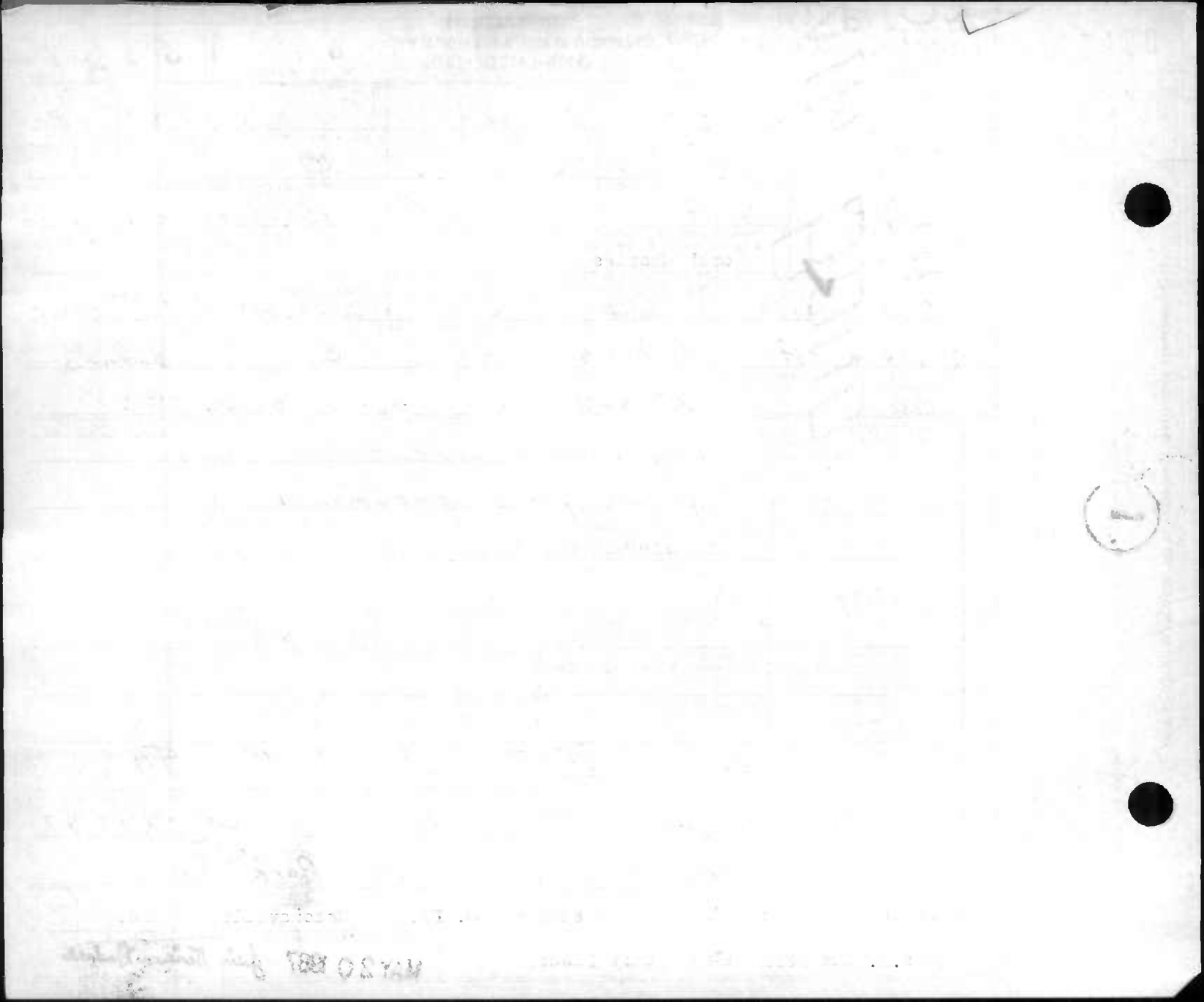
Items 18c per phone
FOR STATE Hosp. 6/12/87 DMRSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 3 3 3 1

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Ralph</u> MIDDLE: <u>A-</u> LAST: <u>Burnes</u>				2a. DATE OF DEATH MONTH: <u>5</u> DAY: <u>14</u> YEAR: <u>87</u>				2b. HOUR <u>7300</u> M			
3. SEX <u>M</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH: <u>8</u> DAY: <u>13</u> YEAR: <u>56</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>30</u> YRS.		IF UNDER 1 YEAR MONTHS: <u></u> DAYS: <u></u>		IF UNDER 72 HRS HOURS: <u></u> MIN: <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore city MD</u>					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>North Charles</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>MD</u>				13b. COUNTY <u>Balt</u>		13c. CITY OR TOWN <u>Balt</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>2022 Mt. Royal Terrace 21217</u>	
14. FATHER'S NAME FIRST: <u>Calvin</u> MIDDLE: <u>H</u> LAST: <u>Barnes</u>				15. MOTHER'S MAIDEN NAME FIRST: <u>Rosa</u> MIDDLE: <u>E.</u> LAST: <u>Barnes</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>217682981</u>		17. INFORMANT <u>Rosa Barnes</u>				ADDRESS <u>421 Oxford Ct. 21201</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pneumocystis pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>immune deficiency (AIDS)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Kaposi's sarcoma of stomach</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> 19 <u>87</u> , to <u>5-14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Scott Touger</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/14/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Scott Touger, MD</u>				22e. ADDRESS <u>3100 Wyman Park Dr</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>5/15/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westview Mem. Pk.</u>		23d. LOCATION CITY OR TOWN: <u>Catonsville</u> COUNTY: <u>Md.</u> STATE: <u></u>					
24. FUNERAL DIRECTOR NAME: <u>Chas. A. Rice FSPA</u> ADDRESS: <u>1300 Eutaw place</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 20 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>					

BP



054047 MAY 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Mr. Purvis informed @ ME's office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 3 8

REG. NO.

FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Ann W. BURNS			5 14 87 25 PM								
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 9 1906			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James O. Wrightson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Fisher			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-34-3136		
17. INFORMANT ADDRESS Elizabeth W. Taylor Balto., Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cessation of Heart beat</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissecting thoracic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Upper GI bleed, R @ hip</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>R @ hip</u>											
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5 8 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fell, R @ hip					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nursing Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1, Oak Place Balto Md.					
22a. I certify that (I) (this hospital) attended the deceased from 5 14 87, and that in (my) (our) approved death or from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mackson			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5 14 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MACKSON, W. S.			22e. ADDRESS 1050 old n. point rd, Balto 21224								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-18-87			23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Md.		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co., Balto., Md.			ADDRESS 4905 York Rd.			25a. DATE REC'D. BY REGISTRAR MAY 19 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

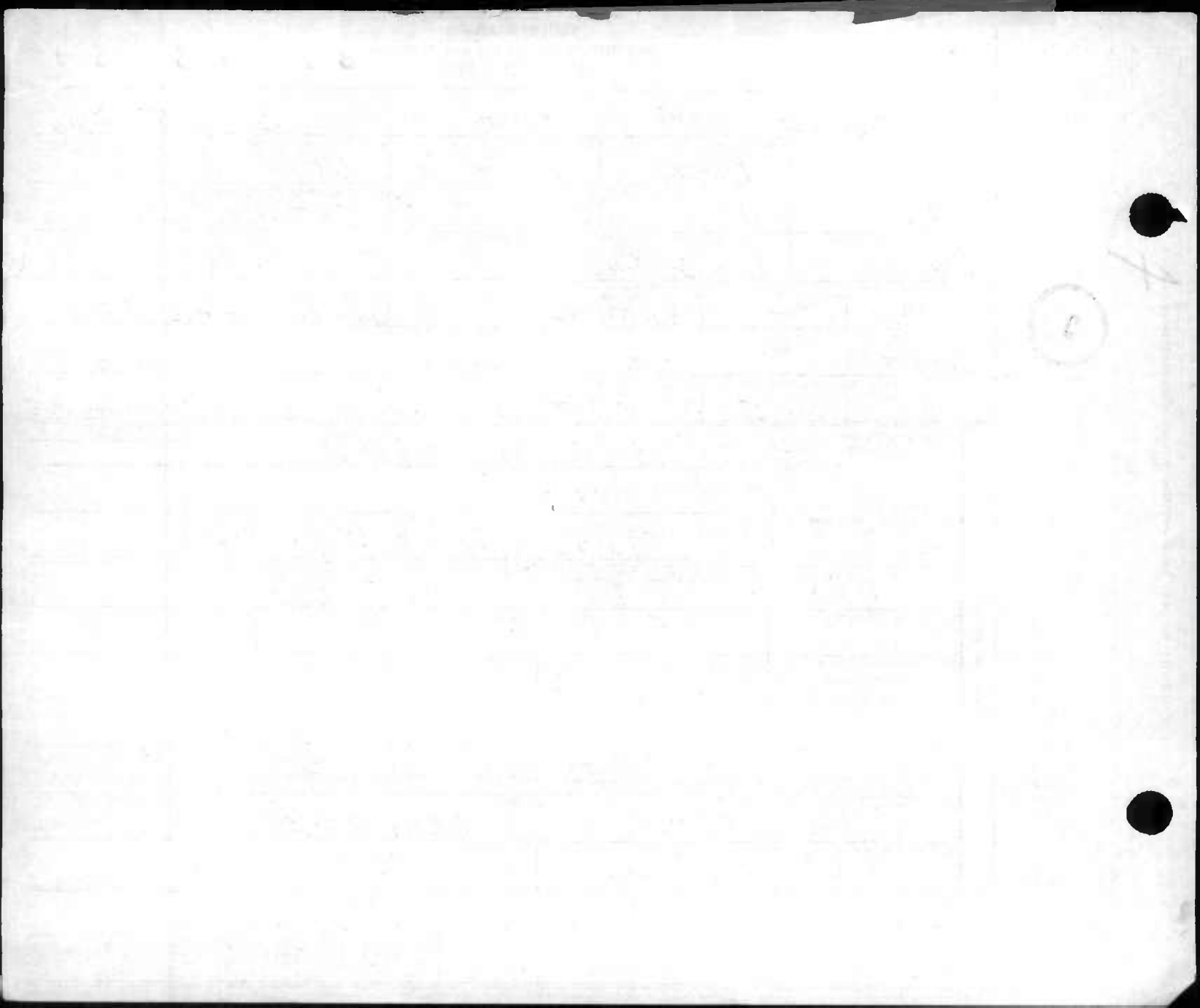
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted on page 4.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) BURNEST NMI BUSH					2a. DATE OF DEATH MONTH 5 DAY 15 YEAR 87 2b. HOUR 8:30 P.M.				
3 SEX M		4. RACE BLACK		5. DATE OF BIRTH MONTH 1 DAY 29 YEAR 18		6. AGE (IN YEARS (LAST BIRTHDAY)) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY MD Drydock	
13a. STATE MD		13b. COUNTY =		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5340 BEAUFORT AVE 21215	
14. FATHER'S NAME FIRST ELBERT MIDDLE LAST BUSH				15. MOTHER'S MAIDEN NAME FIRST LAURA MIDDLE LAST COOK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Carol Cofield		ADDRESS 5332 Beaufort AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF STATES POST TB, ASPERGILLUS (c) STATES								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CRF - Multiple system disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 15 MAY 87 to 15 MAY 87 , that (I) (we) last saw the deceased alive on 15 MAY 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN MEDICAL <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 MAY 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CURTIS EDWARDS				22e. ADDRESS BON SECOURS 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H West ADDRESS 4300 Wabash Ave.				25a. DATE REC'D BY REGISTRAR MAY 19 1987 25b. REGISTRAR'S SIGNATURE [Signature]					

BP



055035 JUN - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

13340

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Shenwood</u> <u>Bushrod</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>05/27/87</u>		2b. HOUR <u>2:30pm</u>
3. SEX <u>Male</u>	4. RACE <u>Black</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>06/19/23</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St Agnes Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>MD</u>		13b. COUNTY	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Harry</u> <u>Bushrod</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary</u> <u>Bushrod</u>		13e. STREET ADDRESS / ZIP CODE <u>972 N. Franklin town Rd 21216</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>217-12-6222</u>		17. INFORMANT ADDRESS <u>Sadie Bushrod 972 N. Franklin town Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Candida respirating Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Breast Car.</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>06/16</u> 19 <u>87</u> to <u>05/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>05/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>\$-Sue</u>		DEGREE		22c. DATE SIGNED <u>5/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Samuel Smith</u>		22e. ADDRESS <u>St Agnes Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/1/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest Vet</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Owings Mills MD</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H West 4300 Wabash Avenue</u>			25a. DATE REC'D. BY REGISTRAR <u>JUN 1 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Jackson-Kendall</u>

MEDICAL CERTIFICATION

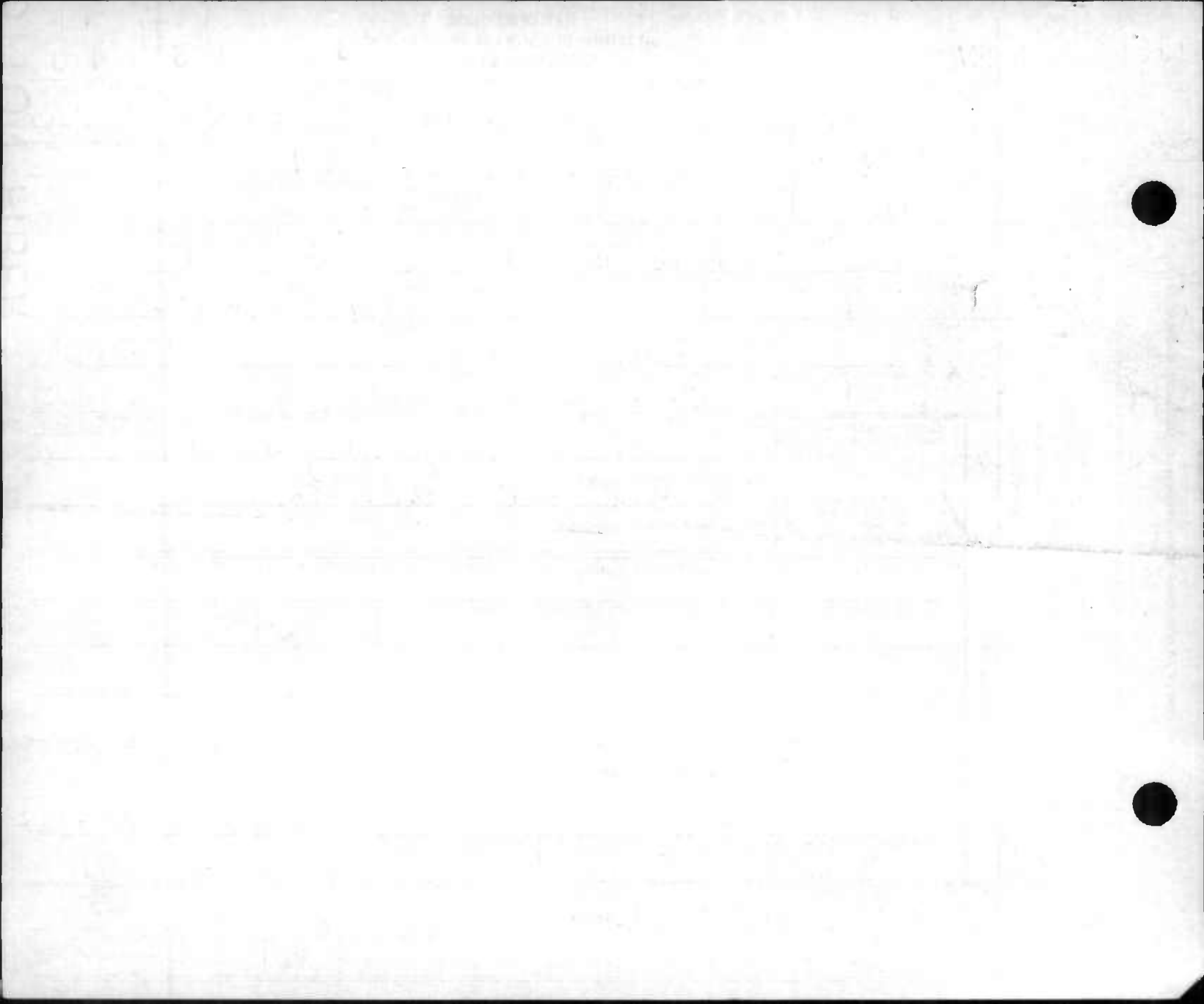
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



52930 MAY 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13341

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR			
EARL			S.			BUTLER, JR.			5-1-87 19			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Black		1 24 46		41 YRS		MONTHS DAYS		HOURS MIN		5-1-87 19		7:26 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MD				USA								Baltimore City MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				32 N. Mount Street				N/A							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. STREET ADDRESS			
MD								Baltimore				24 S. Mount St. 21223			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Alonzo				Butler				Dorothy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				218-44-4747				Thomas Johnson Echo House							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Fatty liver with seizure disorder</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) <u>chronic alcoholism</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED			
<i>John E. Smialek</i>				Chief								5-2-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
John E. Smialek, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				5/8/87				Mt. Zion Cem.				Baltimore MD			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H				1101 E. North Ave.				MAY 8 1987				<i>Wm. C. March</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR AT5 ME (1))



UNION MILITARY

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#2

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **1 3 3 4 2**

FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Jerome Butler						MAY 19 1987				M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Black	5 3 50	37 YRS.			MAY 19 1987				10:38 A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Md.	U.S.A.		Baltimore City MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Union Memorial Hospital	Unemployed	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.		Baltimore	

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Clyde Butler	Wilhelmina Winston

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	N/A	Mrs Wilhelmina Butler 1934 E. 31st.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure Disorder with fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1	
--	--

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE William M. Zane TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER
 EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St., Balto., MD 21201
 DATE SIGNED 5-20-87

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	5-23-87	Baltimore	Baltimore Md.

24. FUNERAL DIRECTOR March Funeral Home ADDRESS 1101 E. North Ave.	25a. DATE REC'D. BY REGISTRAR MAY 22 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>
---	--	---

07/84
 25M
 BP
 DHMH - 17
 (VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE NAME, ADDRESS, AND PHONE NUMBER OF THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORWARDED TO THE FUNERAL DIRECTOR. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



053100 MAY 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3343

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROL LYNN BUTTNER			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5-3-87 19		2b. HOUR M 3:20A
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Nov. 2, 1959	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 27	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Child Care			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5004 Boxhill Ln 21210			
14. FATHER'S NAME FIRST MIDDLE LAST John K. Buttner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan Dannettel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 68 8228		17. INFORMANT ADDRESS Mr. John K. Buttner 5004 Boxhill Ln. -10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:10AM 5-3-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto head-on collision with a van	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME (STREET, FACTORY, FARM, ETC.) expressway		21f. LOCATION Jones Falls Expressway (JFX) a Guilford Avenue Baltimore, Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John E. Smialek</i>		TITLE (SPECIFY) M.D. Chief		MEDICAL EXAMINER DATE SIGNED 5-3-87	
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/6/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
23d. LOCATION CITY OR TOWN Baltimore, Md.		COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Tindon-Rudner</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PMA-3. RETURN PAGE 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

U.S. DEPT. OF JUSTICE
WASHINGTON, D.C.

Mr. Tolson

Dear Mr. Tolson:

I am writing you to advise that

the following information was received from

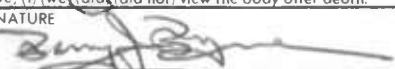

Very truly yours,

Special Agent in Charge

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MICHAEL T. CAIN			2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1987		2b. HOUR 830 A.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 9 85		6. AGE (IN YEARS LAST BIRTHDAY) 2 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3007 ELLERSLIE AVE. 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glennise Cain		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. N/A		
17. INFORMANT Glennise Cain			ADDRESS 21218 3007 Ellerslie Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>ARTERIOHEPATIC DYSPLASIA WITH CONGENITAL HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>85</u> , to <u>MAY 20</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>MAY 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE  M.D.				22c. DATE SIGNED 5-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY J. BYRNE, M.D.				22e. ADDRESS JHH 600 N. WOLFE ST. BALTO., MD. 21205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/23/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE 	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.					

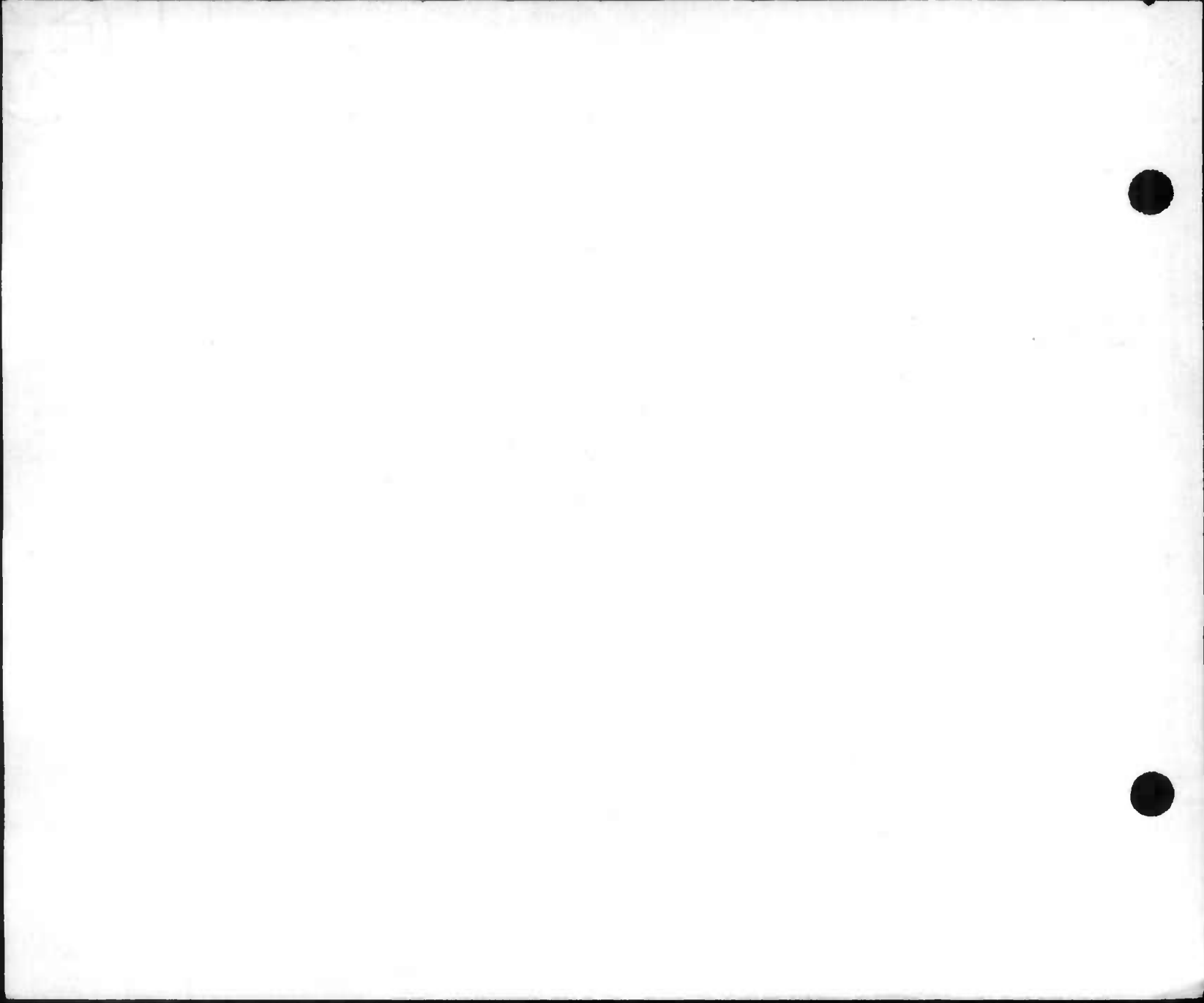
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in advance.

BP



055071 JUN 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 3 3 4 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nancy Caminiti</i>			2a DATE OF DEATH MONTH DAY YEAR <i>05/22/87</i>		2b HOUR <i>4:30 PM</i>
3 SEX <i>FEMALE</i>	4 RACE <i>WHITES</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>APRIL 11, 1912</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY MD</i>	
10 CITY OR TOWN OF DEATH <i>BALTIMORE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MERCY HOSPITAL</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>AT HOME</i>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>		13b COUNTY <i>BALTIMORE</i>	13c CITY OR TOWN <i>BALTIMORE</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>ANTHONY ENRICO</i>		15 MOTHER'S NAME FIRST MIDDLE LAST <i>GRACE ENRICO</i>		13e STREET ADDRESS / ZIP CODE <i>5623 KNOLL AVE 21206</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b SOCIAL SECURITY NO. <i>094 146061</i>		17 INFORMANT ADDRESS <i>FAMILY RECORDS</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Possible Pneumonia</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>05/08</i> , 19 <i>87</i> , to <i>05/22</i> , 19 <i>87</i> that (I) (we) lost saw the deceased alive on <i>05/22</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Keith Friend</i>				22c DATE SIGNED <i>05/22/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Keith Friend</i>				22e ADDRESS	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>5-26-1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>Pinehawn Cem.</i>	
23d LOCATION CITY OR TOWN COUNTY STATE <i>NEW YORK</i>		23e DATE REC'D. BY REGISTRAR <i>JUN 1 1987</i>			
24 FUNERAL DIRECTOR NAME <i>EVANS CHAPEL OF MEMORIES</i>		ADDRESS <i>8800 HARFORD</i>		25b REGISTRAR'S SIGNATURE <i>John A. ...</i>	

MEDICAL CERTIFICATION

99

BP

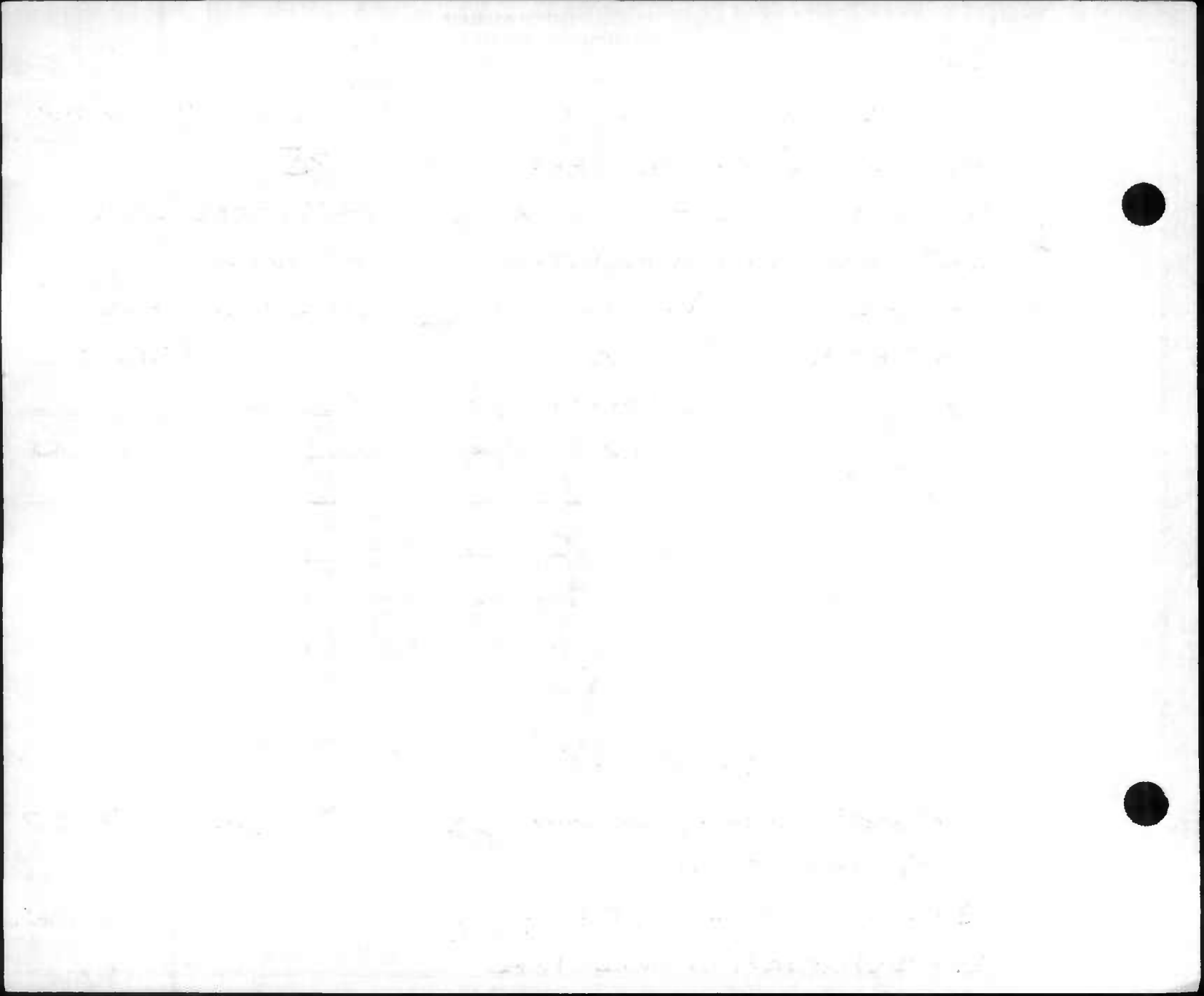
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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in advance.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 4 6

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
THOMAS		CAMPBELL						DATE KNOWN OF DEATH		HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE OF BIRTH		8. DATE OF BIRTH		9. DATE OF BIRTH	
Male	Black	Oct. 27, 1925		61 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA		MARRIED		Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		19 S. Monastery Ave.		Ware-house Manager							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE	
Maryland				Baltimore		YES		19 S. Monastery Ave.		21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS	
James		Hattie		Yes		218-14-3629		Delsie Campbell		5503 Key Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
PART I DEATH WAS CAUSED BY:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		YES		UNDERLYING		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2	
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease				NO		CONTRIBUTING		P.M. 19			
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22a. I certify that I took charge of the remains described above, held an		22b. TIME OF INJURY		22c. HOW INJURY OCCURRED	
WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		Autopsy		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2	
NOT WHILE AT WORK						Inspection		P.M. 19			
						Inquiry					
						and in my opinion					
						death resulted from:					
						Natural causes					
						Accident					
						Suicide					
						Homicide					
						Undetermined manner					
ACTUAL SIGNATURE		EXAMINER'S NAME		ADDRESS		TITLE (SPECIFY)		DATE SIGNED			
		Ann M. Dixon, M.D.		111 Penn St., Balto., MD 2 1201		Deputy Chief		5-26-87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Burial		May 30, 1987		Carroll Western's Cem.		Barstow		MAY 28 1987		Julia...	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. CITY OR TOWN		24d. COUNTY		24e. STATE	
Spencer E. Sewell		Box 31 Prince Fred.		MD20678		Calvert		MD			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR P.M. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NO COLLIMETERS

200



NOTICE

1. The first part of the document is a notice regarding the...
2. The second part of the document is a notice regarding the...
3. The third part of the document is a notice regarding the...
4. The fourth part of the document is a notice regarding the...
5. The fifth part of the document is a notice regarding the...
6. The sixth part of the document is a notice regarding the...
7. The seventh part of the document is a notice regarding the...
8. The eighth part of the document is a notice regarding the...
9. The ninth part of the document is a notice regarding the...
10. The tenth part of the document is a notice regarding the...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Alexander S. Caperna								May 25, 1987										7:15pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Male		Caucasian		Sept. 18, 1916		70 YRS.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City, MD													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		2842 Pelham Ave., 21213		Roofer		Roofing													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE											
Md.				Baltimore				2842 Pelham Ave. 21213											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Louis		Adele																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		217-09-6360		Nenna Marie Caperna (wife)		same address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:																	
		IMMEDIATE CAUSE (a)		Liver failure, Cirrhosis														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				DUE TO, OR AS A CONSEQUENCE OF														3 weeks	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Metastatic cancer to Liver														6 months	
				DUE TO, OR AS A CONSEQUENCE OF															
				(c) Metastatic Adenocarcinoma of Lung to Liver and Brain														9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (this hospital) attended the deceased from November 10, 1986, to May 25, 1987, that (I) (we) last saw the deceased alive on April 30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
Kathy J. Helzlouer M.D.																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Kathy Helzlouer, M.D.		JOHNS HOPKINS HOSPITAL																	
		600 N. Wolfe St, Balto, Md. 21205																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Cremation		5/29/87		Greenmount		Baltimore													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Schlunke Funeral Home, Inc.		MAY 28 1987		Julia Davidson-Randall															
3331 Brehms Lane, Balto. Md. 21213																			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILEY-INTERSCIENCE

053191 MAY 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

1 3 3 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charrienne Mae Casey			2a. DATE OF DEATH MONTH DAY YEAR 5 7 87		2b. HOURS 4:05 A.M.	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 6-2-1948		
7a. BIRTHPLACE (STATE OR FOREIGN) BALTO		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS MONTHS DAYS		
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MED CTR		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO, CITY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY KSP SER		13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		
13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ELMER F BOLLING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH WREN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
16b. SOCIAL SECURITY NO. 215483087		17. INFORMANT ELIZABETH BOLLING		ADDRESS 2819 AVE WOODBRACK		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BREAST CARCINOMA WITH METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 28, 1987, to May 7, 1987, that (I) (we) last saw the deceased alive on May 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Wanda Wicks-Davis MD				22c. DATE SIGNED May 7, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WANDA WICKS-DAVIS				22e. ADDRESS DEATON MEDICAL CENTER		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-12-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk		
23d. LOCATION BALTO		23e. COUNTY MD		23f. STATE		
24. FUNERAL DIRECTOR NAME Beaton Thompson F.H.				25. DATE REC'D. BY REGISTRAR MAY 11 1987		
25a. REGISTRAR'S SIGNATURE Julia Davidson				25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1

054201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13350

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUNE M. CARLSON		2a. DATE OF DEATH MONTH DAY YEAR MAY 19, 1987		2b. HOUR 4:30A M	
1. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1935	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
10. CITY OR TOWN OF DEATH BALTIMORE		1. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank teller		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1702 Tarrytown Ave. 21114			
14. FATHER'S NAME FIRST MIDDLE LAST James H. Gilpin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Dempster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 055-26-4671		17. INFORMANT David A. Carlson same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC CHOLANGIOCARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ACUTE RENAL FAILURE 2° GRAM NEGATIVE SEPSIS</u>					
19a. DATE OF OPERATION 1/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PAINLESS JAUNDICE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> , 19 <u>87</u> , to <u>MAY 19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MAY 19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Carolyn Hendricks MD		DEGREE		22c. DATE SIGNED 5-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROLYN HENDRICKS MD		22e. ADDRESS 650 N. WOLFE ST, BALD 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Beall Funeral Home		25a. ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25b. DATE REC'D. BY REGISTRAR MAY 20 1987	
		25c. REGISTRAR'S SIGNATURE John Hendricks			

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach the coroner's papers. Page 2 should be retained within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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054435 MAY 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13351

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOBART G. CARRIER			2a. DATE OF DEATH MONTH DAY YEAR MAY 19, 1987		2b. HOUR P M 3:25 P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 2, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Talon Industries
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2439 Boston Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Euphrastus Carrier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Arvilla DeHass			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b. SOCIAL SECURITY NO. 177-03-7646		17. INFORMANT ADDRESS Audrey C. Hickman 2439 Boston Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ARRHYTHMIA						40 minutes
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 5/18 19 87 to 5/19 19 87 , that (1) (we) last saw the deceased alive on 5/18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.						
22b. SIGNATURE Sydney S. Lyon				DEGREE MD		22c. DATE SIGNED 5/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SYDNEY LYON				22e. ADDRESS JOHNS HOPKINS HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-24-87		23c. NAME OF CEMETERY OR CREMATORY Roselawn Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Meadville, Pennsylvania
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		24b. ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Roads		

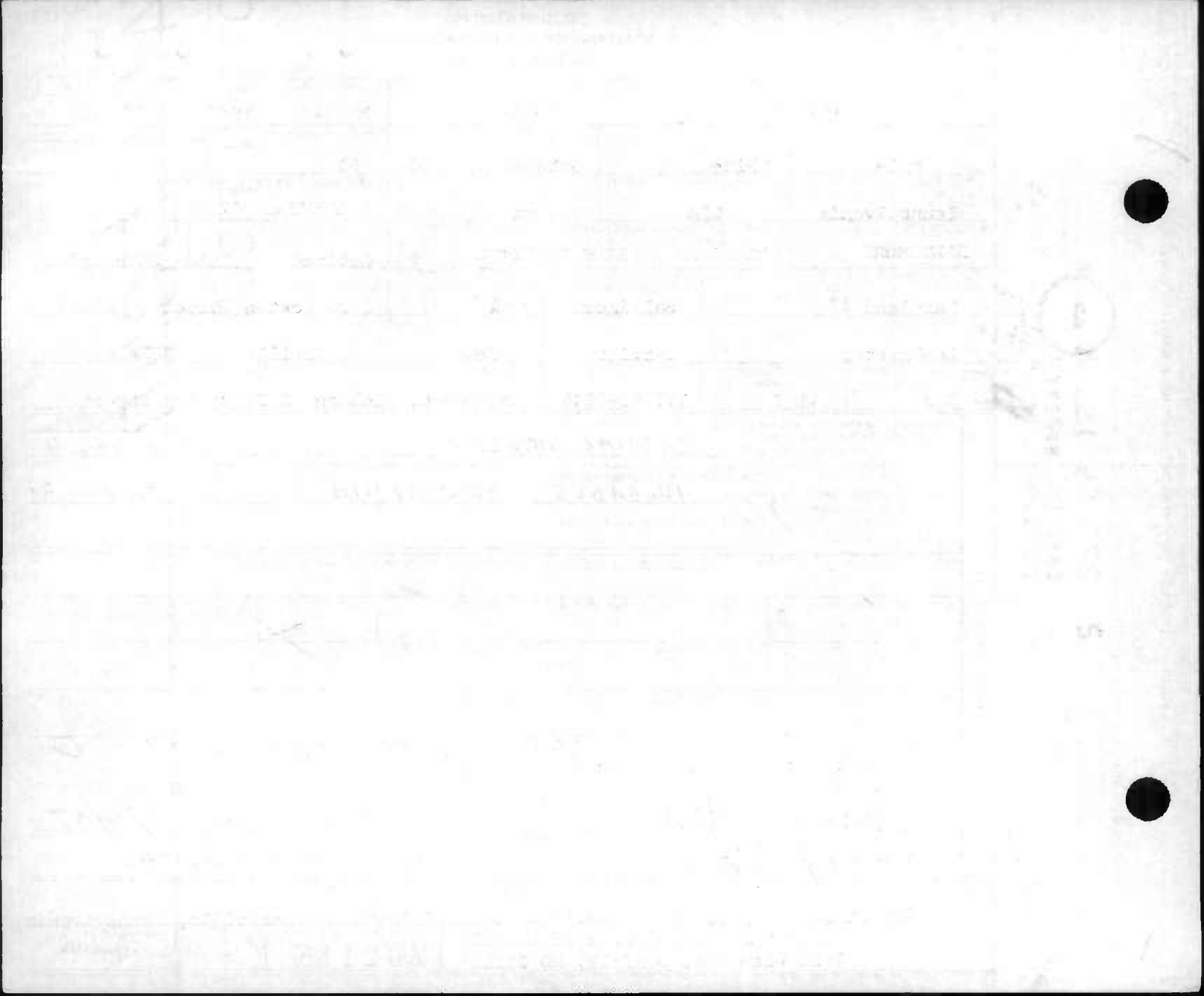
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the funeral, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, this death certificate must be filed with the State Dept. of Health and Mental Hygiene.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 5 2

1. FOR
STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LAURA

E.

CARRINGTON

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

11 28 30

6. AGE (IN YEARS)

55

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE

8. MONTH

9. DAY

10. YEAR

11. HOUR

5-2-87

19

4:40P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Baltimore

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

264 Ballou Court

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Unemployed

12b. KIND OF BUSINESS OR INDUSTRY

-

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS

264 S. Ballou Ct. 21231

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Junious

Venable

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Maude

Knight

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

215284112

17. INFORMANT

264 Ballou Ct. 21231
Carlton S. Carrington

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

diabetes mellitus, obesity

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 5-3-87

EXAMINER'S NAME (TYPE OR PRINT)

John E. Smialek, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

5/9/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

23d. LOCATION

Ann Arundel, Co. Md.

COUNTY STATE

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H 1101 E. North Ave.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAY 7 1987

25b. REGISTRAR'S SIGNATURE

Julia Swider-Radner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1000, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25A

BP

DHMH - 17
(VR A15 ME (5))

Handwritten text, possibly a list or notes, including the word "PROVIDE" and a circular stamp or seal.

Handwritten mark or signature.

053400 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 3 3 5 3

FOR
STATE
REGISTRAR

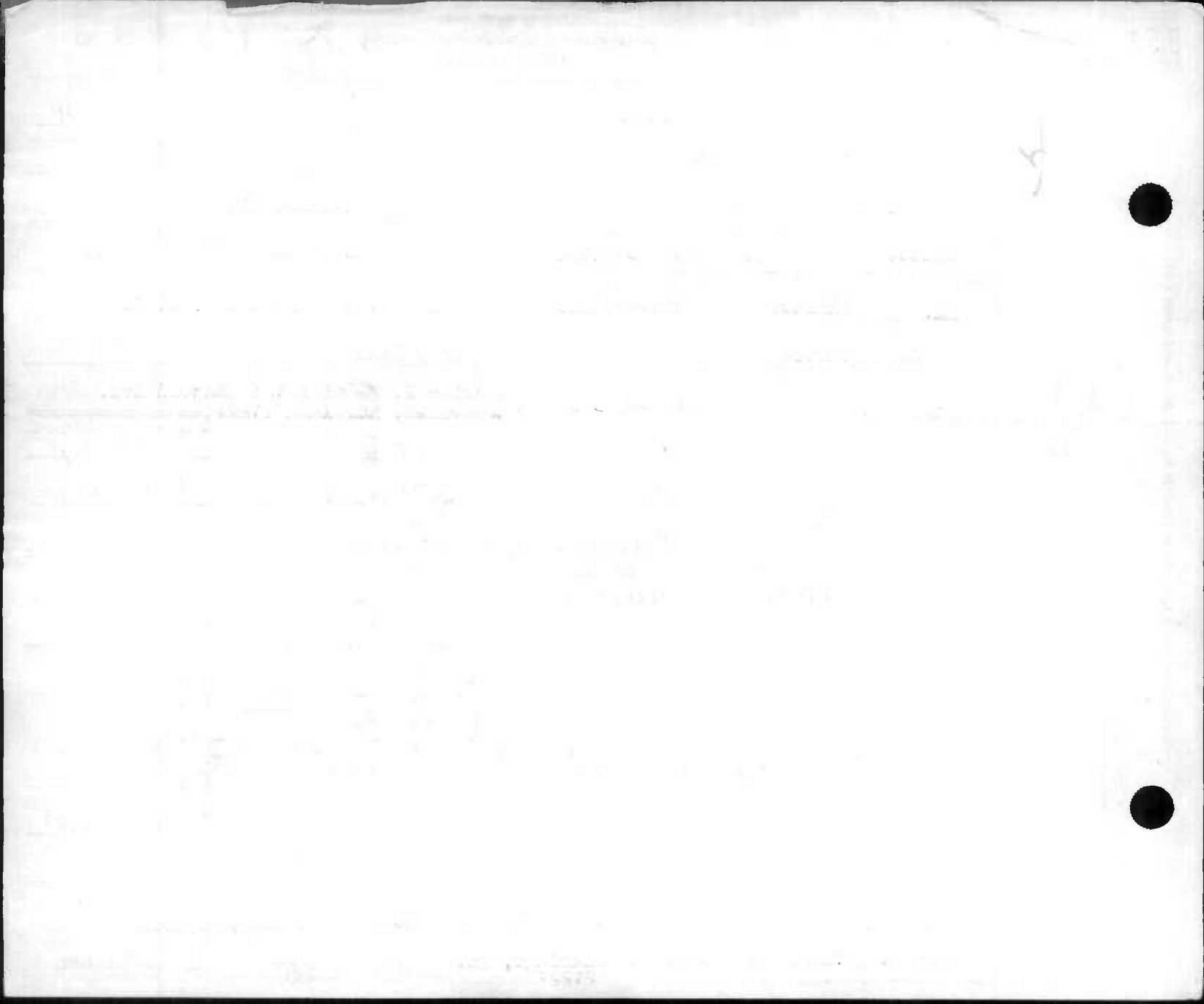
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Martha Carruthers			2a. DATE OF DEATH MONTH 5 DAY 7 YEAR 87			2b. HOUR 3:42P M		
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH 5 DAY 22 YEAR 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE Norwood LAST 			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Hahn LAST 		16. SOCIAL SECURITY NO. 217 26 0383			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 26 0383		17. INFORMANT ADDRESS Catherine I. Mancini 146 Sanford Ave. Catonsville, Maryland 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ATHEROSCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2-3 days YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 DIABETER MELLITUS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (s) (this hospital) attended the deceased from MAY 7 , 19 87 , to MAY 7 , 19 87 , that (we) last saw the deceased alive on MAY 7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Bert F. Morton						22c. DATE SIGNED May 8, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON						22e. ADDRESS ST. AGNES HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/9/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE		
24. FUNERAL DIRECTOR Gary L. Kaufman 5695 Main St. Elkrige, Md. 21227				25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE Lola Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified or called.



056245 JUN 10 1987

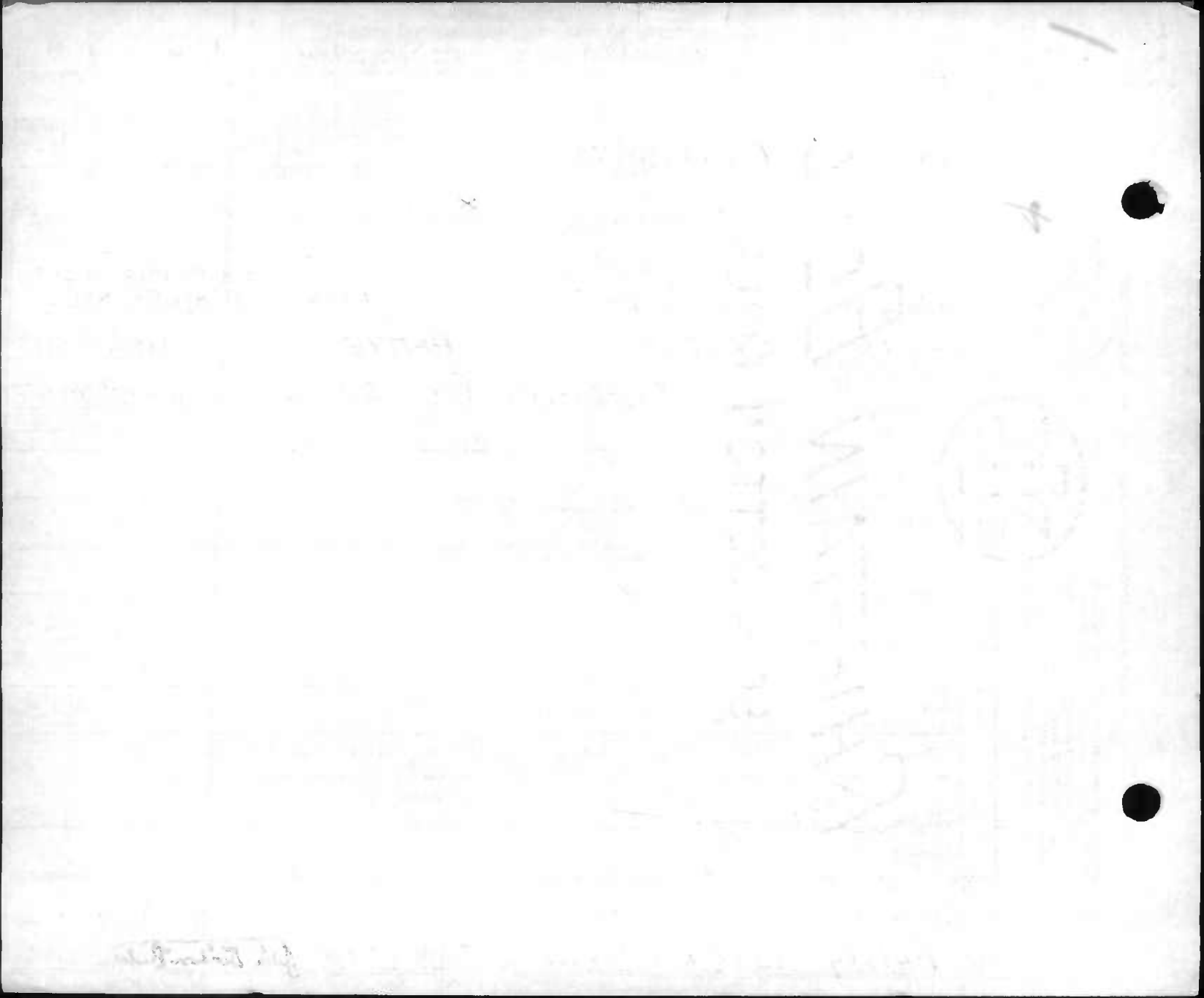
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-101. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 5 4

1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2c. HOUR	
		Ernest		Carter						2b. DATE KNOWN OF DEATH		5		21		1987		12:46	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE		BLACK		10-22-1914		72 YRS.						5		21		1987		12:46	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
md		U.S.A.		MARRIED		NEVER MARRIED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		University Hospital																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
md				BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BALTO, MD, 21217											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
James		HATTIE																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
[YES, NO, OR UNKNOWN]		218-07-6685		PEARL CARTER		1304 W. LAFAYETTE AVE.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.											
				Arteriosclerotic cardiovascular disease															
				(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY)		DATE SIGNED													
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Assistant		5/21/87													
ACTUAL SIGNATURE		M.D.		ADDRESS		DATE SIGNED													
William M. Zane, M.D.				111 Penn St.		5/21/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED		REGISTRAR'S SIGNATURE													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		5/25/87		GARRISON Forrest		OWINGS Mills md													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
V. Bailey		JUN 10 1987		Julia Seaton-Randall															
1348 N. CALHOUN ST																			



054097 MAY 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8713355
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LOUISE W. CARTER		5 18 87		1031 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	BLACK	8 8 23	63 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
BALTIMORE	USA		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	LIBERTY MEDICAL CENTER	UNEMPLOYED			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3816 BONNER ROAD 21216	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
JAMES H. WALKER	NANCY HERRING	NO			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
220-14-7553		Bernice Smith		3816 Bonner Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) CHRONIC KIDNEY FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					
(c) DIABETIC NEPHROSCLEROSIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/18, 1987, to 5/19, 1987, that (I) (we) lost					
saw the deceased alive on 5/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
[Signature]		M.D.		5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
REED A. WINSTON		2600 LIBERTY HARBOR AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	5/21/87	Arbutus Mem. Pk.	Arbutus, Md		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H West		MAY 19 1987		[Signature]	
ADDRESS					
4300 Wabash Ave.					

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 1-3356
REG. NO.1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE		MIDDLE VICTORIA		LAST CARTER		2a. DATE OF DEATH MONTH MAY DAY 05 YEAR 1987		2b. HOUR 10:45 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH MARCH DAY 9 YEAR 1900		6. AGE 87 YEARS (LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 05 DAYS 26 HOURS 10 MIN. 45	
7a. BIRTH PLACE (CITY OR TOWN) Virginia		7b. CITIZENSHIP (WHAT COUNTRY?) USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4504 Fairview Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE NAME AND ADDRESS) M.D.		13b. COUNTY BALTO		13c. CITY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4504 Fairview Avenue 21216	
14. FATHER'S NAME FIRST Richard MIDDLE Veney LAST ?				15. MOTHER'S MAIDEN NAME FIRST Cremora MIDDLE ? LAST ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. DATE OF DEATH 216-36-3765		17. INFORMANT ADDRESS 21216 Justine Carter Jones 4504 Fairview Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma to liver DUE TO, OR AS A CONSEQUENCE OF (b) (primary site unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH July 1986									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, GIVE MEDICAL EXAMINER'S)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/9 19 87 to 5/9 19 87 , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE D. W. Stewart, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/11/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. W. STEWART		22e. ADDRESS 2300 Garrison Blvd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.		23d. LOCATION CITY OR TOWN Arbutus, Baltimore Co. COUNTY Md. STATE Md.			
24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr. ADDRESS 4101 Edmondson Ave				25a. DATE RECEIVED BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

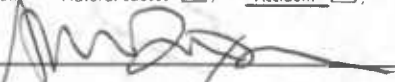
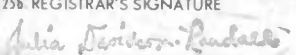
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

Center

100% Cotton



054533 MAY 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3357
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN CASCIO						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 22 1987		2b. HOUR M 10:09 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-26-1924	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 22 1987		2d. HOUR M 10:09 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert & Lexington Sts.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Warehouseman		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 118 S. Ann St. 21231		
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Cascio				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Paura						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-16-1606		17. INFORMANT ADDRESS Esther Bowman, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 10:08M MONTH DAY YEAR 5-22-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by auto.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Calvert & Lexington Sts., Balto. City, MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER				DATE SIGNED 5-23-87		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-27-87		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.						25a. DATE REC'D. BY REGISTRAR MAY 25 1987		25b. REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713358

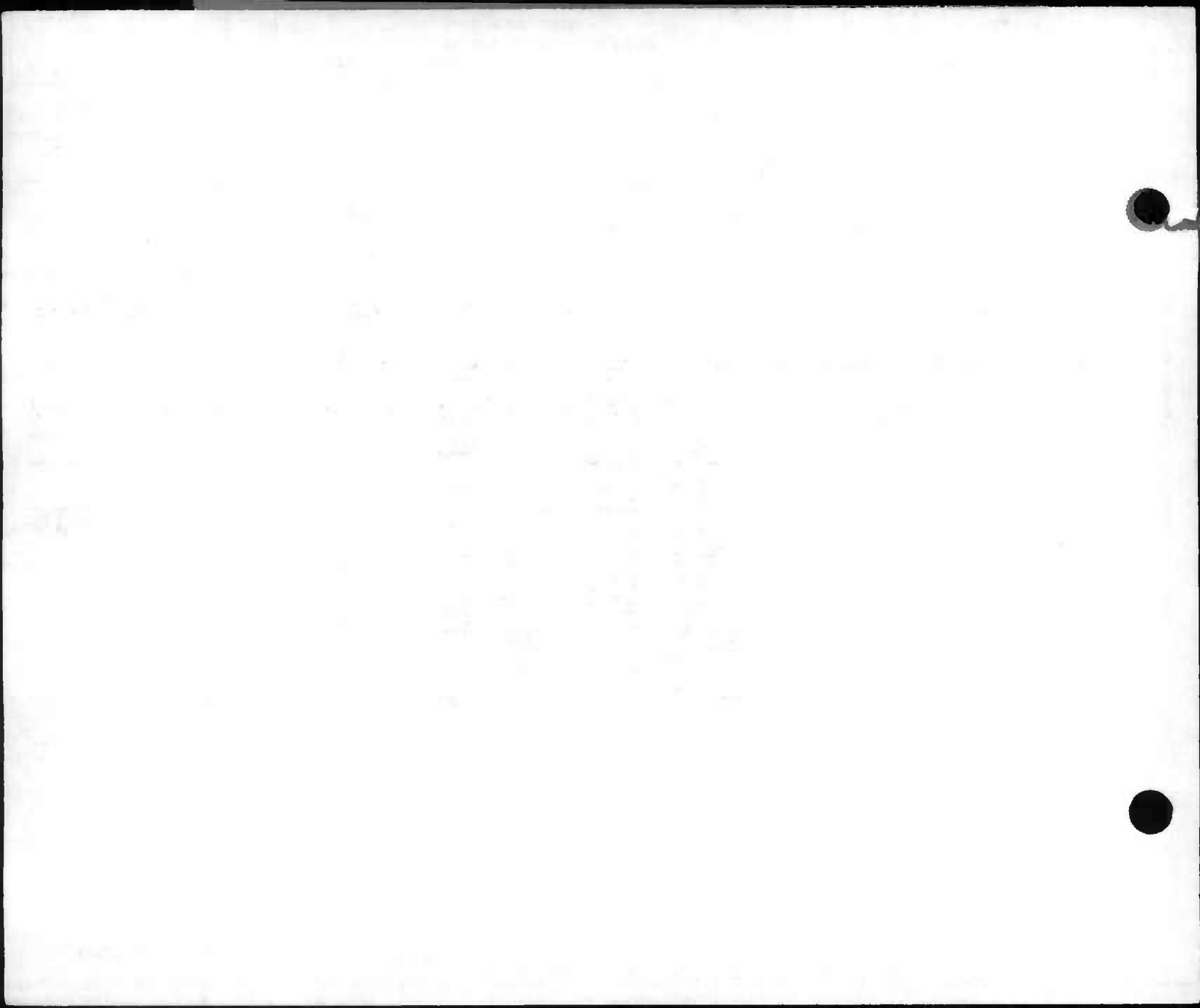
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		H. HOUR	
Lola M. Chamberlain				5-24-87		12A		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR	
F	NEGRO	9 22 24		62		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTIMORE MD	U.S.A			BALTIMORE MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Liberty Med. Centre			HOMEMAKER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND				BALTIMORE				1010 W. BALTIMORE ST 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
MACOLM P. CHAMBERLAIN		ROXANNA MOODY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		215 247 151		MR ANNIE C. SMITH 1915 MCKEAN AVE 521217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Peripheral vascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4/24/87		Peripheral vascular dis							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/25</u> , 19 <u>87</u> , to <u>5/24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Dr Samuels		MD				5/24/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr Samuels		Liberty Med - Center							
23a. BURIAL, CREMATION, REMOVAL (IF)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION OR TOWN COUNTY STATE			
BURIAL		5-29-87		ARABUTUS MEM PARK		BALTO Co, Md			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
JOSEPH L. RUSS		2122 W. NORTH AVE		MAY 28 1987		Julia S. Gordon-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner would be notified at once.

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713359
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bryson J Champ			2a. DATE OF DEATH MONTH DAY YEAR 5/14/87		2b. HOUR 1:13A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3/18/36		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 51	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY H.C.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARTS MANUFACT		12b. KIND OF BUSINESS OR INDUSTRY G.M.C.
13a. STATE W.VA		13b. COUNTY PUTNAM	13c. CITY OR TOWN PETERBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW J CHAMP		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL ALT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 232-62-6246		17. INFORMANT ADDRESS ALTA K. CHAMP 102 TRENTON ST W.VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Overdose with Improper Phenobarbital, Ethanol. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/13 , 19 87 , to 5-14 , 19 87 , that (I) was last saw the deceased alive on 5/13 , 19 87 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will (did) not view the body after death.					
22b. SIGNATURE R.W. Wisner-Carlson, MD		DEGREE		22c. DATE SIGNED 5/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.W. Wisner-Carlson		22e. ADDRESS Francis Scott Key Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-17-87		23c. NAME OF CEMETERY OR CREMATORY LAHMANVILLE CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE LAHMANVILLE GRANT W.VA		24. FUNERAL DIRECTOR NAME HAIGHT F.H. Box 45 Sykesville, MD 21784		25a. DATE REC'D. BY REGISTRAR MAY 15 1987	
		25b. REGISTRAR'S SIGNATURE John D. ...			

MEDICAL CERTIFICATION

BP

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87		13360	
1. FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Chandler					2a DATE OF DEATH MONTH DAY YEAR 5/30/87					2b HOUR 8 A M			
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 8/1/12			6 AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD						
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (Home) 717 Portland St.					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Md.		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 717 Portland St 21230					
14 FATHER'S NAME FIRST MIDDLE LAST Dozier Brockington					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie T. Brockington								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 220-14-5522		17 INFORMANT ADDRESS Bertha Jones 5 Haroldwood Ct. 21207									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 03/1 87 550 87								
22a I certify that (I) (this hospital) attended the deceased from <u>5/28</u> 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Kuang-Yen Huang</u>					DEGREE M.P.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>5/31/87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>KUANG-YEN HUANG M.D</u>					22e ADDRESS <u>517 SCOTT ST BALTO MD 21230</u>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 6/3/87		23c NAME OF CEMETERY OR CREMATORY Arbutus Park			23d LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.					
24 FUNERAL DIRECTOR NAME Chas.A.Rice					FSPA 1300 Eutaw Place			25a DATE REC'D. BY REGISTRAR JUN 2 1987		25b REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>			

100-1073140

100-1073140

100-1073140

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13361

REG. NO.

1 - FOR
STATE
REGISTRAR

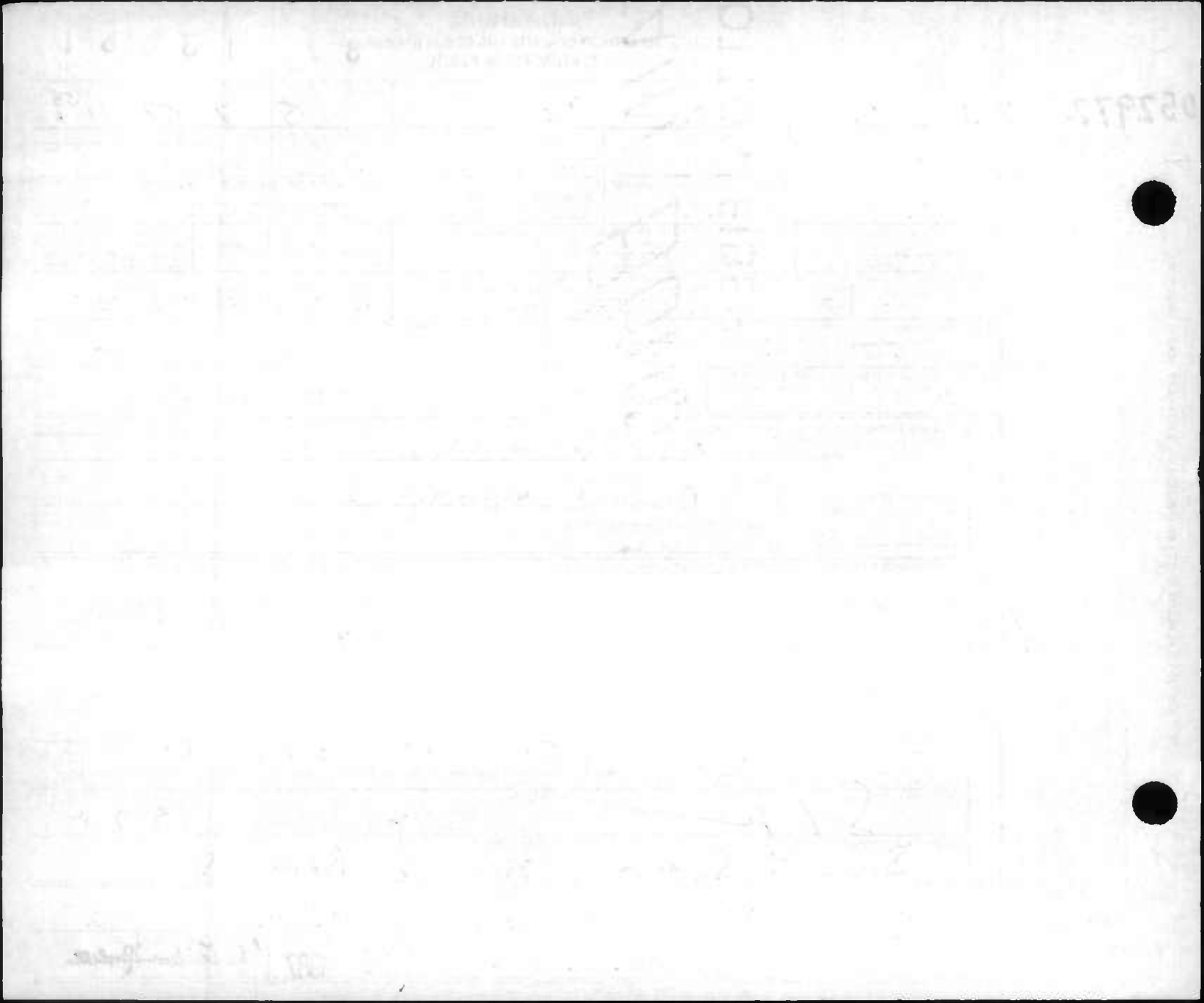
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRIAN M. CHANEY			2a. DATE OF DEATH MONTH DAY YEAR 5 7 87		2b. HOUR 11:53 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 17 1965		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION
13a. STATE MD.		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MORGAN P. CHANEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN M. KUS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-96-8323		17. INFORMANT ADDRESS ANN CHANEY (MOTHER) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fulminant Hepatitis B</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5:1 to 5:7, 1987, that (I) (we) last saw the deceased alive on 5-7-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED 5-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Simon V. Scarpa		22e. ADDRESS 2800 E. BALTO. ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/9/87	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR'S NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213			25a. DATE REC'D. BY REGISTRAR MAY 11 1987		
			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13362

1- FOR
STATE
REGISTRAR

55293

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 07 Eras G. CHAPPELL

2a. DATE KNOWN OF DEATH ESTI MATED MONTH DAY YEAR 5-27 1987 2b. HOUR M 7:41A

3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 1/29/38 6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2309 McElderry Street 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafe Worker 12b. KIND OF BUSINESS OR INDUSTRY Restaurant

13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 2309 McElderry St., 21205

14. FATHER'S NAME FIRST MIDDLE LAST Eras C. Chappell 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Skinner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 242 50 4691 17. INFORMANT ADDRESS Eras G. Chappell, Edenton, NC

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant M.D. DATE SIGNED 5-27-87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 5/29/87 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD

24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212 25a. DATE RECD BY REGISTRAR JUN 2 1987 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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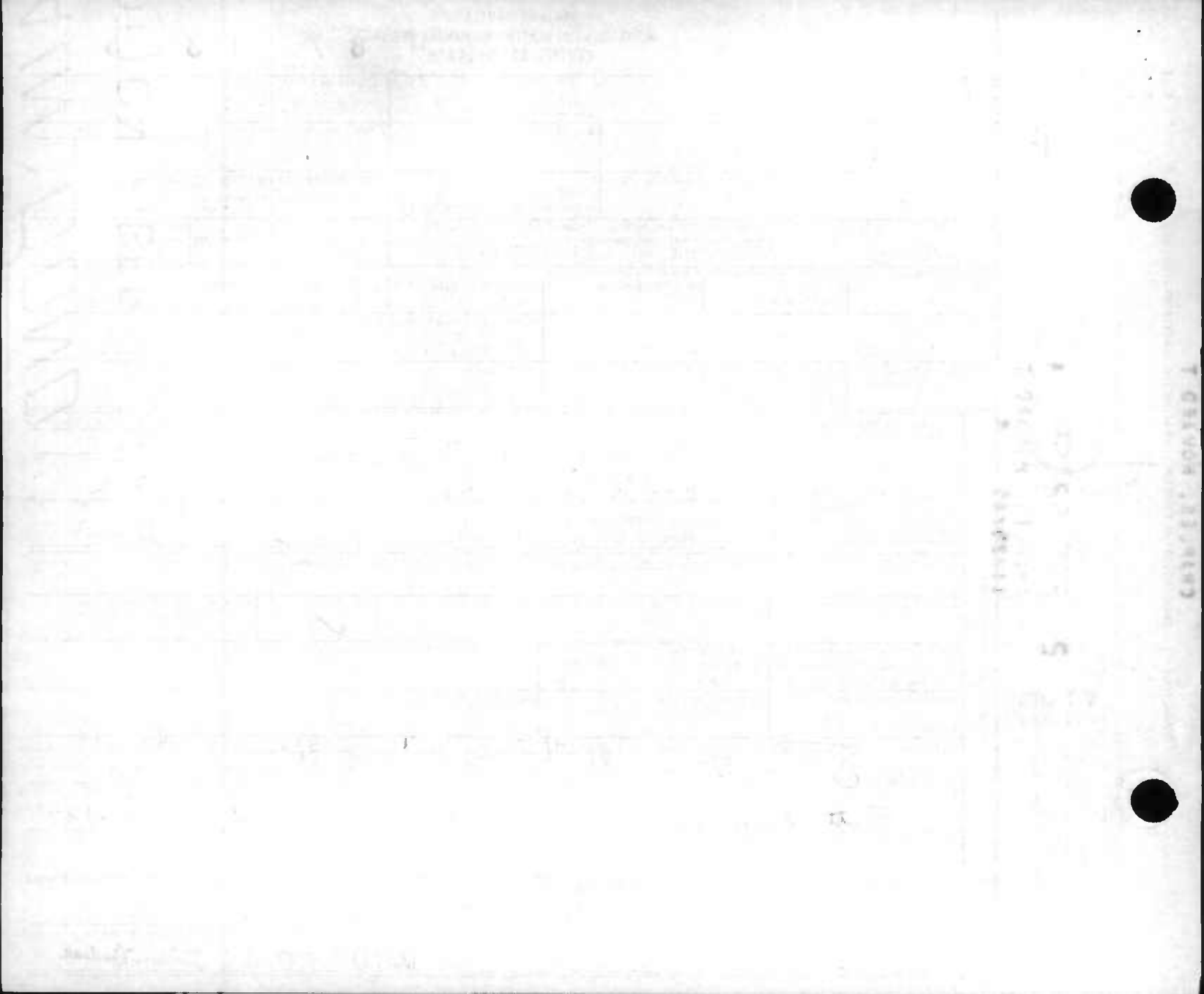
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 6 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD Thomas CHARLES			2a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1987		2b. HOUR 9:15P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 25 45		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY PA State	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA 13b. COUNTY Perry 13c. CITY OR TOWN Penn Twp. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE RD# 3 Box 232, Duncannon PA 9999								
14. FATHER'S NAME FIRST MIDDLE LAST Howard E. Charles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Mourey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam		17. INFORMANT ADDRESS RD# 3, Box 232 Constance Charles, Duncannon, PA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of unknown primary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 wk 12 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/15, 19 87, to 5/4, 19 87, that (I) (we) lost saw the deceased alive on 5/4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.								
22b. SIGNATURE Scott Kaufman M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/87		23c. NAME OF CEMETERY OR CREMATORY Indiantown Gap Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE W. HANOVER Lebanon PA		
24. FUNERAL DIRECTOR NAME Michael J. Shalonis				ADDRESS 206 Maple Ave. Marysville, PA		25a. DATE REC'D. BY REGISTRAR MAY 08 1987		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13364

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERMAN CHEEK			2a. DATE OF DEATH MONTH DAY YEAR 05 03 1987		2b. HOUR 6 25 AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 19 13	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 616 ARCHER STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY REFRACTURES
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST CHEEK, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST POLLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.		16b. SOCIAL SECURITY NO. 237 106780		17. INFORMANT MRS. ELIZABETH CHEEK ADDRESS BALTO. MD. 21230 616 ARCHER STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-26, 1987 , to 5-3, 1987 , that (I) (we) last saw the deceased alive on 4-2, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William R. Law DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. LAW MD		22e. ADDRESS 38N SECOURS HOSPITAL 2000 W. BALTIMORE ST BALTO. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/7/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND					
24. NAME OF FUNERAL HOME NUTTER & SONS FUNERAL HOME, INC.		25a. DATE REC'D. BY REGISTRAR MAY 6 1987		25b. REGISTRAR'S SIGNATURE Julia Swider-Rudner	
25c. ADDRESS 2501 GWYNNS FALLS PKWY, BALTO. MD. 21216					

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BACK

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FRISCHER

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053492 MAY 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

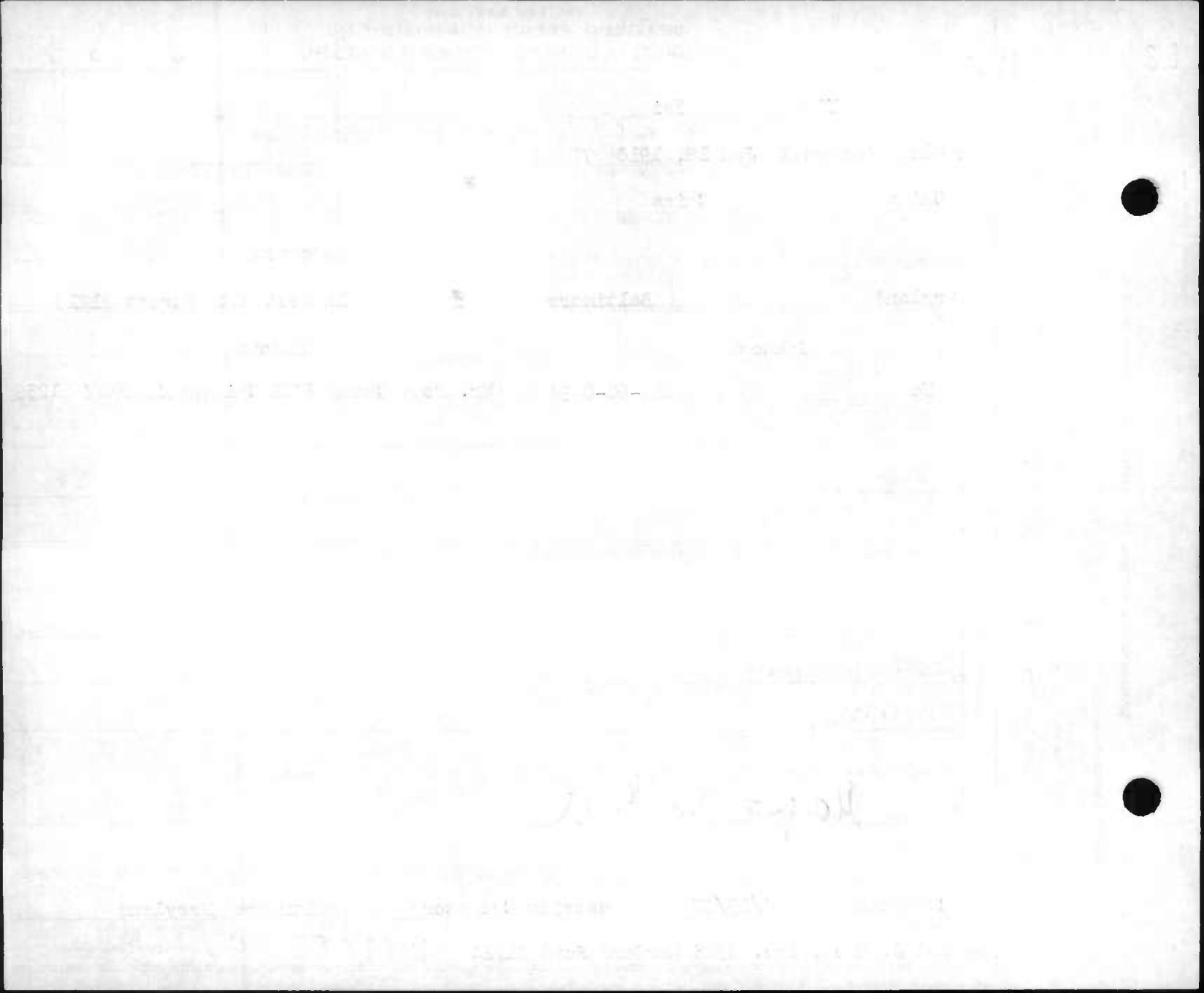
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOUR PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 3 6 5	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Ying Fai Cheng										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 9 1987	
3. SEX Female 4. RACE Oriental 5. DATE OF BIRTH MONTH DAY YEAR Jan 18, 1910 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. 7. CITIZEN OF WHAT COUNTRY? China 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 9 1987 2d. HOUR 8:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China 7b. CITIZEN OF WHAT COUNTRY? China 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.											
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 W. 20th Street 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 11 West 20th Street 21218											
14. FATHER'S NAME FIRST MIDDLE LAST Unknown 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 215-60-0894 17. INFORMANT ADDRESS Mr. Tony Cheng 5711 Chinquapin PKWY 21239											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5/10/87											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto.MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 5/13/87 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. 5305 Harford Road 21214 25a. DATE REC'D. BY REGISTRAR MAY 13 1987 25b. REGISTRAR'S SIGNATURE Julia Sidorov-Randner											

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))



052721 MAY 78

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

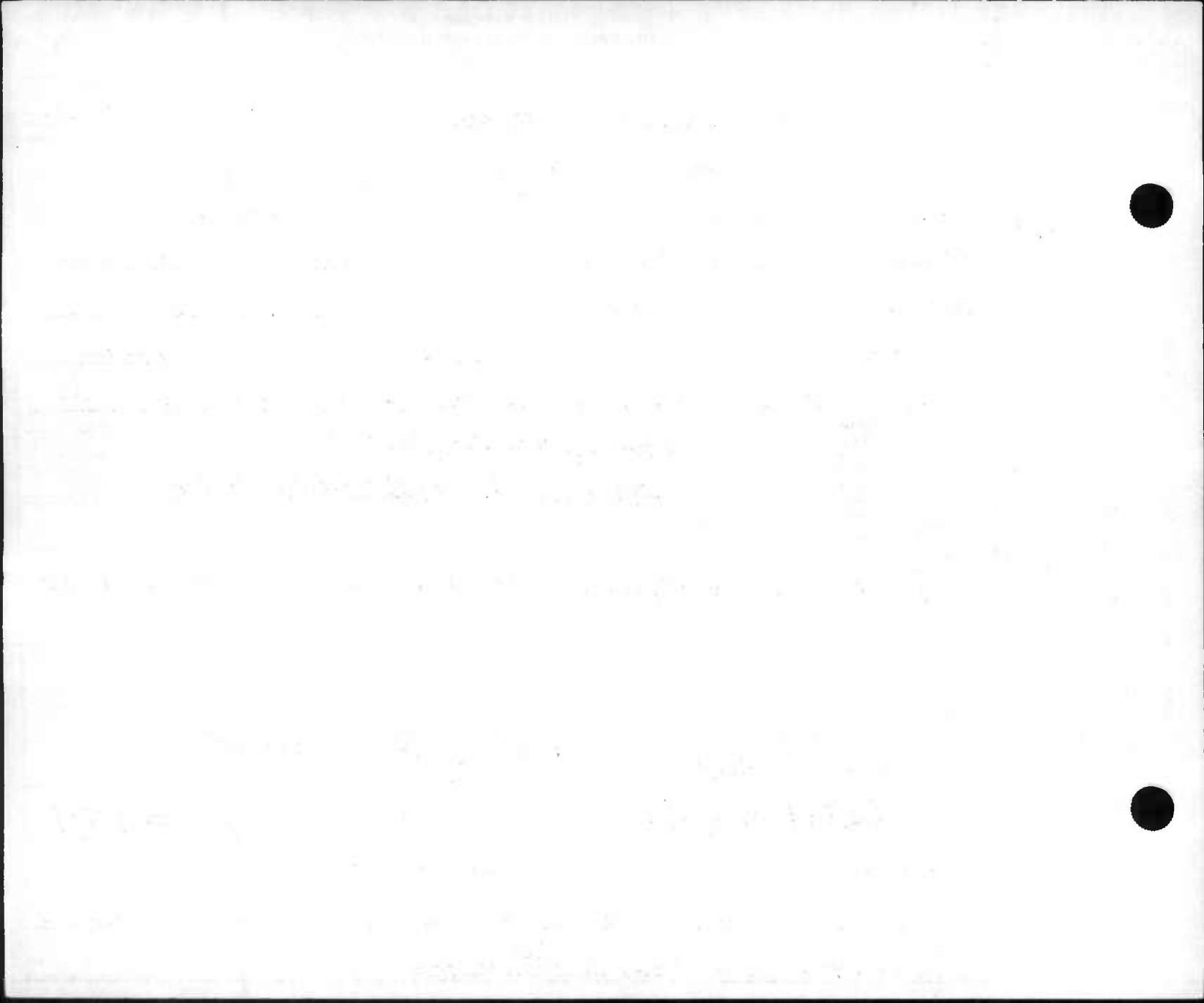
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13366

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH ALEXANDER CHEPAITIS			2a. DATE OF DEATH MONTH DAY YEAR 5 4 87		2b. HOUR 12:15A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 30 13		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 229 S. Gilmore Street		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Chepaitis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Wonsowicz		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215-07-0543		17. INFORMANT ADDRESS Anna Chepaitis 229 S. Gilmore St. 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ① Ventricular arrhythmias ② chronic obstructive pulmonary disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/31 , 19 83 , to present , 19 87 , that (I) (we) last saw the deceased alive on 3/13/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE CD Kearney MD		DEGREE		22c. DATE SIGNED 5/5/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kearney		22e. ADDRESS Washington Village				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR 5-9-87		
25b. REGISTRAR'S SIGNATURE		25c. COUNTY Baltimore				
25d. STATE Maryland						

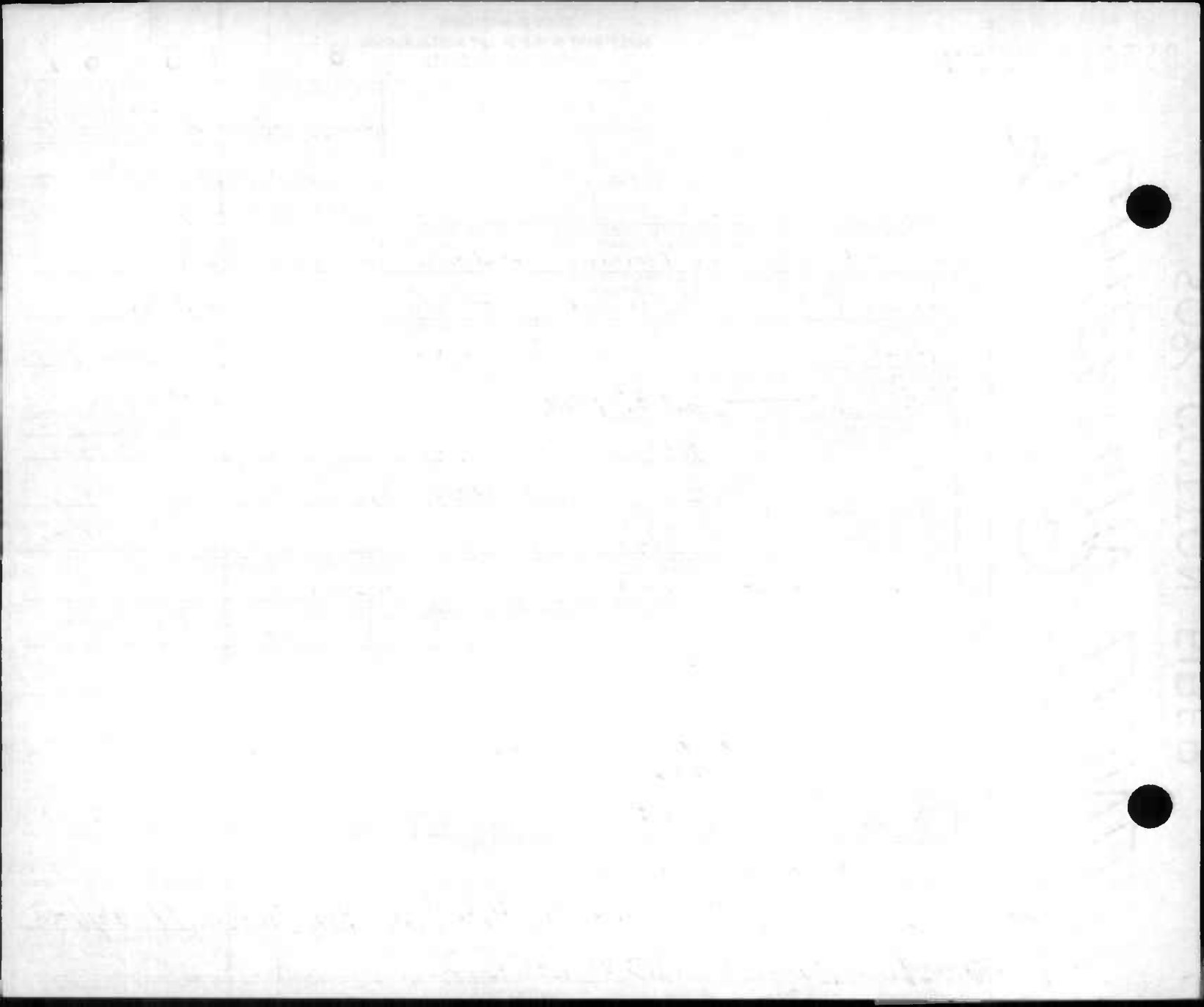


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit, along with carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR		87		13361		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
Ella						Christian		5 28 87 11:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
F		N		8 21 15		71		11:05 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Virginia		U.S.				Baltimore City		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
South Baltimore General Hosp.		domestic worker				50 W. West St.		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Paul		Martha		UNK		814-34-9772		Reseca Wilson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?		21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22. DATE SIGNED	
PART I. DEATH WAS CAUSED BY:		19. CONDITION FOR WHICH OPERATION WAS PERFORMED		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		5-28-87	
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Intracerebral Hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hypertension</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
<u>Arteriosclerotic Cardiovascular heart disease</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION		21e. PLACE OF INJURY	
		HOUR A.M. MONTH DAY YEAR				STREET CITY OR TOWN COUNTY STATE		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
5-28-87 to 5-28-87, that (I) (we) last saw the deceased alive on		Dr. Crevelom, MD		5-28-87		Mark K. Rosenbaum, MD		3001 S. Hanover, Baltimore, MD 21230	
above, (I) (we) (did) (did not) view the body after death.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
BURIAL		6-3-87		Cedar Hill Cem.		Baltimore, Maryland		JUN 2 1987	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
Brown/Thompson F.H.		1913 W. BALTO., ST							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 1 3 3 6 8	
1. FOR STATE REGISTRAR		DECEASED NAME		2a. DATE OF DEATH		2b. HOUR					
		FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	HOURS	MIN.		
		ANTHONY	Joseph	CIRRI	05	24	87	3:15	PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		10-10-1917		69		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		GOOD SAMARITAN HOSPITAL		Inspector		Black & Decker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS & ZIP CODE			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4339 Seidel Ave. 21206			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Salvatore				Rose				Cerrito			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
yes		WW II		218-05-6862		Catherine Cirri (wife) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>LUNG CANCER</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>BRAIN METASTASIS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (this hospital) attended the deceased from <u>05/03</u> , 19 <u>87</u> , to <u>05/24</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>05/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>A. K. Khowli</i>				MD				05/24/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
FADI KHOWLI MD				GOOD SAMARITAN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		5/27/87		GARDENS OF FAITH		BALTIMORE				MD.	
24. FUNERAL DIRECTOR'S NAME						25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCHMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						MAY 28 1987		<i>John S. ...</i>			

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101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700

701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13369

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frank Hume Clark			2a. DATE OF DEATH MONTH DAY YEAR May 16 1987			2b. HOUR M AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5501 Key Avenue, 21215				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor-Residential		12b. KIND OF BUSINESS OR INDUSTRY Painting	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5501 Key Ave., 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Baum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Anna Adams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -					
16b. SOCIAL SECURITY NO. 218-12-6011A		17. INFORMANT ADDRESS Rose A. Honemann, 2318 Harcroft Rd., 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ✓ Carbox anox DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ✓ 8:15									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Alzheimer's Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 4-15 1987 to May 17 1987 that (I) (we) last saw the deceased alive on 4-15 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Stanley R. Steinbach				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-18-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley R. Steinbach, M.D.				22e. ADDRESS 11 Slade Avenue					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/18/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS J. E. Lowell Lemmon, 10 W. Padonia Rd.				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



LIBRARY

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8713370

1. DECEASED NAME (TYPE OR PRINT) HATTIE		FIRST CLARK		LAST CLARK		2a. DATE OF DEATH MONTH MAY 16, 1987		2b. HOUR P 4:52	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 88		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RICHMOND VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST Samuel MIDDLE Ellis LAST Ellis		15. MOTHER'S MAIDEN NAME FIRST Rachael MIDDLE Ellis LAST Ellis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220146828		17. INFORMANT Virginia Murray ADDRESS 1622 N. Durham St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC DISEASE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 HRS 48 HRS 10 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET BALTIMORE		21g. CITY OR TOWN BALTIMORE		21h. COUNTY BALTIMORE	
22a. I certify that (I) (this hospital) attended the deceased from 5/14/87 19 87 to 5/16/87 19 87 that (I) (we) lost saw the deceased alive on 5/16/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE Brian V. Ward		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian V. Ward				22e. ADDRESS BALTIMORE				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/21/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION CITY OR TOWN Baltimore Md.		23e. COUNTY Baltimore	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				24a. ADDRESS Baltimore		24b. DATE RECEIVED BY REGISTRAR MAY 20 1987		24c. REGISTRAR'S SIGNATURE Wm. C. March	

1120

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a report, with some words like "Bureau", "Department", and "Washington" visible. There are also some numbers and possibly names, but they cannot be accurately transcribed.]

[Faint text lines follow, including what might be a title or a header for a section, such as "Bureau of Plant Industry".]

[The body of the text consists of several paragraphs of very faint, mostly illegible text. Some words like "Bureau", "Department", and "Washington" are visible, along with some numbers and possibly names.]

[The text continues with more faint, illegible lines, possibly a list or a report.]

[The final section of the page contains more faint, illegible text, possibly a conclusion or a signature block.]

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **1 3 3 7 1**

1. DECEASED NAME (TYPE OR PRINT)		FIRST NEIL		MIDDLE DAVID		LAST CLARK		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 5 19 87		2b. HOUR 12:50 P M	
3 SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 13 1922		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 65		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 19 87		7d. HOUR 12:50 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2823 Mosher St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) M.H. CHARGE ATT.		12b. KIND OF BUSINESS COMMONWEALTH OF VIRGINIA HOSP.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2823 W. MOSHER, BALTIMORE, MARYLAND 21216			
14. FATHER'S NAME FIRST MIDDLE LAST CARY CLARK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LE ANNA TIMMONS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 215-18-6356		17. INFORMANT MR. BALTIMORE, MD. 21216 ALTON CLARK 2823 W. MOSHER STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5-19-87			
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/27/1987		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VET. CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE, MARYLAND			
24. NAME OF FUNERAL HOME WATNER FUNERAL HOMES, INC.		ADDRESS 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>					

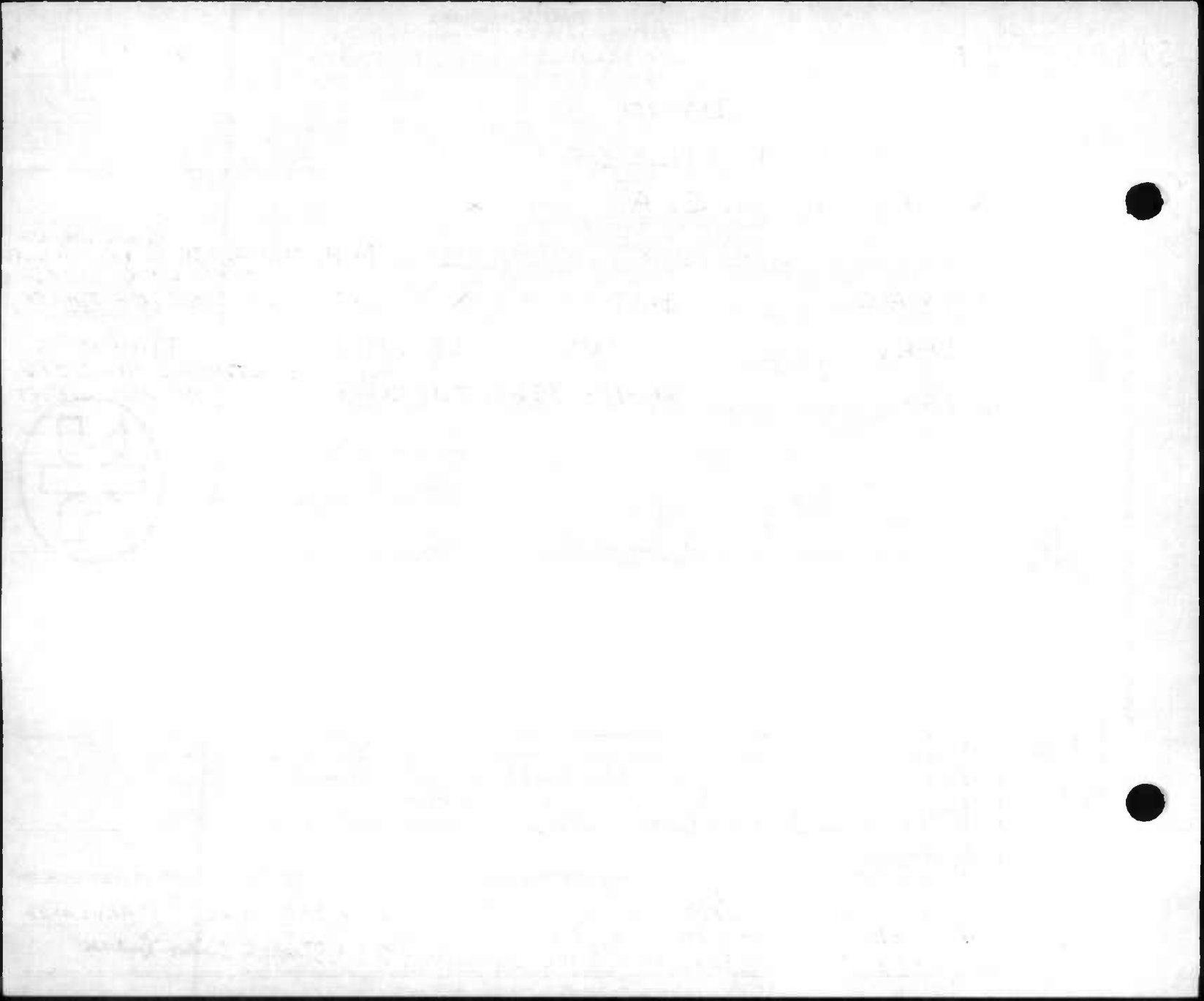
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

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DHMH - 17
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054665 MAY-20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 3 7 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amelia M. Clay			2a. DATE OF DEATH MONTH DAY YEAR 05 26 87		2b. HOUR 1:30A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-22-1904	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2409 Chesterfield Ave. 21213	
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14. FATHER'S NAME FIRST MIDDLE LAST John Zarbos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO. 212-26-5032	17. INFORMANT John Jos. Clay - 2409 Chesterfield Ave.-21213
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>GI Bleeding, Poss. Ischemic Bowel</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 1 day	
--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hx bleeding ulcers, aspirin use.</u>			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (1) (this hospital) attended the deceased from <u>5/25</u> 19 <u>87</u> , to <u>5/26</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>5/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.	
--	--

22b. SIGNATURE <u>Susan G. Weiner</u>	DEGREE MP	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>5/26/87</u>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Weiner MD	22e. ADDRESS Union Memorial Hospital
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE 5-28-87	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
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24. FUNERAL DIRECTOR NAME John C. Miller, Inc.-6415 Belair Rd.-21206	25a. DATE REC'D. BY REGISTRAR MAY 27 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Dandrea-Randall</u>
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20% OFF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13373

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST Arnold		MIDDLE -		LAST CLAYTON		2b. DATE OF DEATH MONTH DAY YEAR		5 17 87		2c. HOUR 0635A			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR		03 04 49		6. AGE (IN YEARS LAST BIRTHDAY) YRS		38		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md Hospital		12a. KIND OF BUSINESS OR INDUSTRY		MD			
13a. CITY OR TOWN OF DEATH Baltimore		13b. STATE MD		13c. COUNTY Baltimore		13d. CITY OR TOWN Owings Mills		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE Rosewood State Hosp. 21117		14. FATHER'S NAME FIRST MIDDLE LAST Archie Clayton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Gibbs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u>		19a. DATE OF OPERATION <u>5-8-87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>empyema</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>5-13-87</u> , 19 <u>87</u> , to <u>5-17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Susan E. Thomas</u> MD		22c. DATE SIGNED <u>5-17-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Susan E. Thomas</u>		22e. ADDRESS <u>22 S. Green St Baltimore MD 21201</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/21/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Landsdown, Md.</u>		24. FUNERAL DIRECTOR NAME <u>Wm C March F/H West</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 20 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

103 OCT 24

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **1 3 3 7 4**

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) HOYT CLAYTON			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-12-87			2b HOUR 7:30A		
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 9 22 1908	6 AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS 78	IF UNDER 24 HRS. HOURS MIN. 78	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 5-12-87		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2324 Calverton Hgts.			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		
13a STATE Maryland			13b COUNTY			13c CITY OR TOWN Baltimore		
14 FATHER'S NAME FIRST MIDDLE LAST George			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arden White			16a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b SOCIAL SECURITY NO. 217-07-0051			17 INFORMANT ADDRESS 2324 Calverton Hgts. 21216		

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE **Maryland** 13b COUNTY **Baltimore** 13c CITY OR TOWN **Baltimore** 13d INSIDE CITY LIMITS? YES ☐ NO ☐ 13e STREET ADDRESS **2324 Calverton Hgts. 21216**

14 FATHER'S NAME FIRST MIDDLE LAST **George** 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Arden White**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** 16b SOCIAL SECURITY NO. **217-07-0051** 17 INFORMANT ADDRESS **2324 Calverton Hgts. 21216**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Gunshot wound of head**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) **subject shot self with a 38 caliber handgun**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **? P.M. 5-12-87** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) **subject shot self with a 38 caliber handgun**

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) **residence** 21f LOCATION CITY OR TOWN **Baltimore** COUNTY **Maryland** STATE **Maryland**

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE **Margarita A. Korell** TITLE (SPECIFY) **M.D. Assistant** MEDICAL EXAMINER DATE SIGNED **5-12-87**

EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

23a. BURIAL, CREMATION, REMOVAL **Burial/ Bailey** 23b. DATE **5-15-87** 23c. NAME OF CEMETERY OR CREMATORY **Arbutus Memorial Park** 23d. LOCATION CITY OR TOWN **Arbutus** COUNTY **Maryland** STATE **Maryland**

24 FUNERAL DIRECTOR NAME **Bailey Funeral Home** ADDRESS **1348 N. Calhoun St. 21217** 25a. DATE REC'D. BY REGISTRAR **MAY 13 1987** 25b. REGISTRAR'S SIGNATURE **[Signature]**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

3. 10. 1941
1941-10-10

1941-10-10

1941-10-10

53596 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR STATE REGISTRAR item 6, G627 5/2											
REG. NO. 1 3 3 7 5											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. DATE PRONOUNCED DEAD	
JARROD T. CLAYTON						5-12-87		5-12-87		8AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		Black		10 4 66		20 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED			
MD.				U.S.A.				NEVER MARRIED			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION			
Baltimore				1703 E. Chase Street				N/A			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN			
MD.								Baltimore			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.			
THEODORE J. CLAYTON				LUCRETIA WALLACE				N/A			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?				17b. SOCIAL SECURITY NO.				17c. INFORMANT			
NO				N/A				THEODORE CLAYTON 5700 EASTBURY AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gunshot wound of chest (unspecified)											
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LOST.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
				? P.M. 5-12-87				subject shot by police			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY				21f. LOCATION			
				apartment				1703 E. Chase Street Baltimore, Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE			
Margarita A. Korell, M.D.				Assistant				5-12-87			
EXAMINER'S NAME				ADDRESS							
(TYPE OR PRINT)				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
CREMATION				5-18-87				GREENMOUNT			
24. FUNERAL DIRECTOR				23d. LOCATION				23e. DATE REC'D. BY REGISTRAR			
MARCH FUNERAL HOME				BALTIMORE, MD.				MAY 15 1987			
NAME				ADDRESS				REGISTRAR'S SIGNATURE			
1101 E. NORTH AVE.								Julia Davidson-Rodriguez			

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MAY 1 1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 7 6
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Warren</u> MIDDLE <u>ALFRED</u> LAST <u>CLAYTON</u>			2a. DATE OF DEATH MONTH <u>4</u> DAY <u>12</u> YEAR <u>87</u>		2b. HOUR <u>6:50</u> PM
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>12</u> DAY <u>28</u> YEAR <u>10</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>West Va</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CITY</u> MD.		
10. CITY OR TOWN OF DEATH <u>BALTO CITY</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FSK MC</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>W. VA</u> 13b. COUNTY <u>HARDY</u> 13c. CITY OR TOWN <u>OLD FIELDS</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>RFD 99999</u>	
14. FATHER'S NAME FIRST <u>FLOYD</u> MIDDLE <u>CLAYTON</u> LAST <u>CLAYTON</u>		15. MOTHER'S MAIDEN NAME FIRST <u>OLIVE</u> MIDDLE <u>CLAYTON</u> LAST <u>CLAYTON</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>218 18 3810</u>		17. INFORMANT <u>HESTER CLAYTON - OLD FIELDS, W. VA. 26845</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis epriary of stomach/spleen</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malignant Ascites</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Progressive 2 to tumor under treatment</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Severe Carcinomatosis

19a. DATE OF OPERATION <u>4/2/87</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PALCIATION 7 Obstructive tumor</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22. I certify that (I) (this hospital) attended the deceased from 4/2, 19 87, to 4/17, 19 87, that (I) (we) last saw the deceased alive on 4/17, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>CLIFFORD Solomon MD</u>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>4/12/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CLIFFORD Solomon</u>	22e. ADDRESS <u>FSK MC</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>4/21/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>	23d. LOCATION CITY OR TOWN <u>MOORESBURG, W. VA</u> COUNTY <u>HARDY</u> STATE <u>W. VA</u>
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24. FUNERAL DIRECTOR NAME <u>Harry W. Haight</u> ADDRESS <u>Sydney, Md.</u>	25. DATE REC'D. BY REGISTRAR <u>MAY 08 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>
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O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, signs 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4-2

4-2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

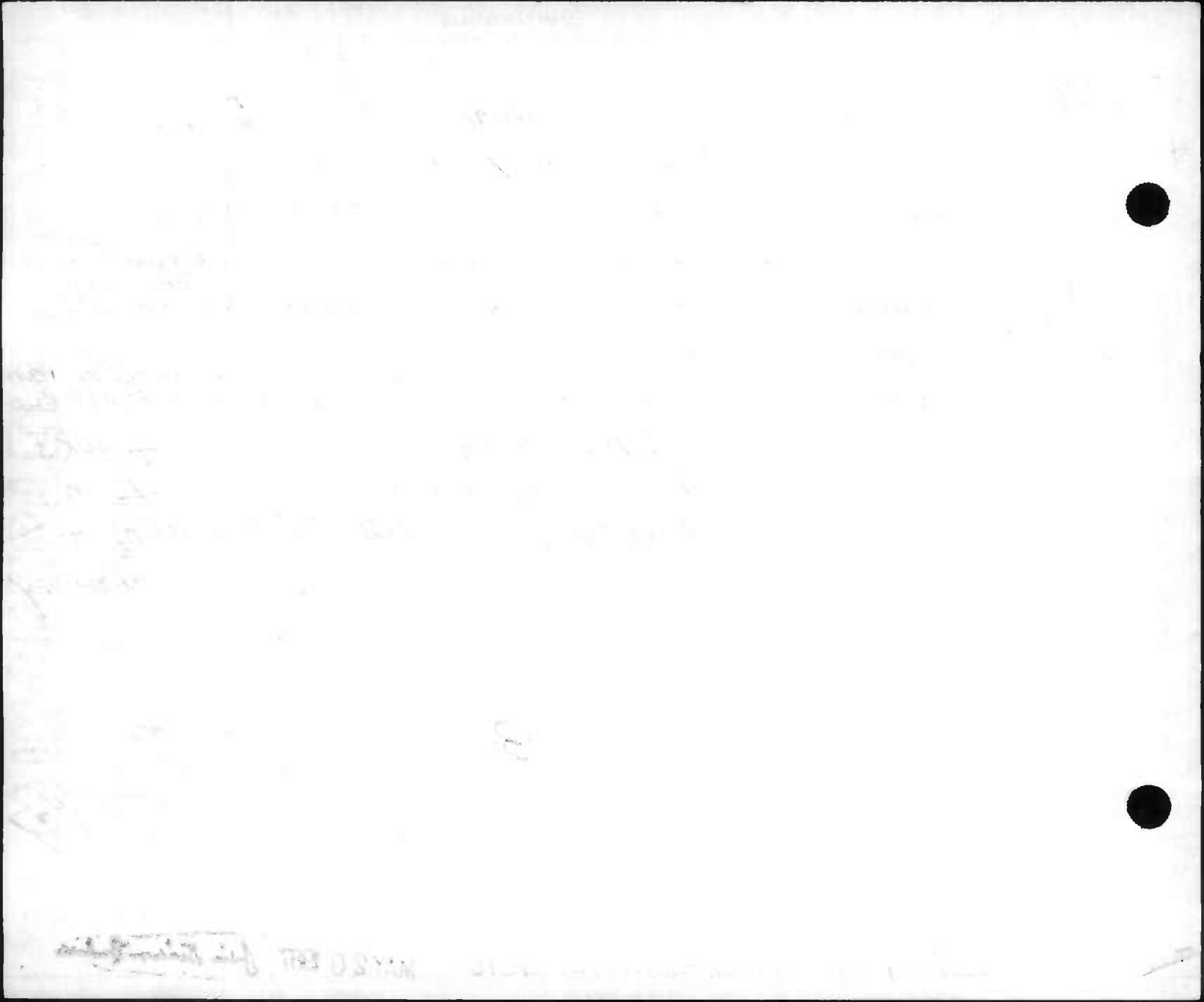
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713377

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARRIE L. CLEM			2a. DATE OF DEATH MONTH DAY YEAR 5-15 87		2b. HOUR 7:40 A.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 7 15		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MGR. COOK	
12b. KIND OF BUSINESS OR INDUSTRY KIBBE'S REST.		13a. STREET ADDRESS / ZIP CODE BALTO. MD. 2418 FREDERICK AVE. 21223			
13b. COUNTY MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GILLIAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 231-32-2151		17. INFORMANT MRS. BRENDA M. McBRIDE ADDRESS BALTIMORE, MD. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) PELVIC ABSCESES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) RUPTURED SIGMOID DIVERTICULITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WKS 4 "					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ACUTE RENAL FAILURE, CONSUMPTION COAGULOPATHY					
19a. DATE OF OPERATION 5/7/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PELVIC ABSCESES		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 3/16 87 5/15 87	
22a. I certify that (in this hospital) attended the deceased from 5/15 87 to 5/15 87 ; that (if (we) last saw the deceased alive on 5/15 87 above, (I) (we) (did) (did not) visit the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD.		22c. DATESIGNED 5/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/22/1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		24. FUNERAL HOME OR OTHER INSTITUTION NAME ADDRESS UNITED FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216			
25a. DATE REC'D. BY REGISTRAR MAY 20 1987		25b. REGISTRAR SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713378

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Inez Cockrell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5/13/87</i>		2b. HOUR <i>1145 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>41 28 22</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i>		MD		
10. CITY OR TOWN OF DEATH <i>Balt</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <i>4018 Boarnan Ave 21215</i>				
13b. COUNTY <i>MD</i>		13c. CITY OR TOWN <i>Balt</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Abraham Elmore</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Evie Thomas</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>225-34-7615</i>		17. INFORMANT ADDRESS <i>Thomas Cockrell 4707 Three Oaks Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic Adeno Ca Uth Et</i> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Praig Cuddy</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/13/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Praig Cuddy</i>		22e. ADDRESS <i>Sinai Hospital Balt MD</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/18/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King Memorial Park</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Randallstown MD</i>		24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H West 4300 Wabash Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 18 1987</i>		
25b. REGISTRAR'S SIGNATURE <i>Julia Sinden-Rodgers</i>						

MEDICAL CERTIFICATION

WAL 2 8 2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) COFFEY, William S.		2a. DATE OF DEATH MONTH DAY YEAR 5-5-87		2b. HOUR 12.55pm	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08-23-08		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender		12b. KIND OF BUSINESS OR INDUSTRY Hotel		13. STREET ADDRESS / ZIP CODE 1115 A D'Long Road 21228.	

13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville	
14. FATHER'S NAME FIRST MIDDLE LAST Mortimer -- Coffey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence --- Foster		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II	
16b. SOCIAL SECURITY NO. 218-18-6137		17. INFORMANT Wife: Mrs. Marie A. Coffey		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary artery disease	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/5 , 19 87 , to 5/5 , 19 87 , that (I) (we) lost saw the deceased alive on 5/5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Grimes		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22i. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Grimes MD		22e. ADDRESS St. Agnes Hosp					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory-Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
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24. FUNERAL DIRECTOR NAME ADDRESS Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE Julia T. R. R. R.	
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BP

RECEIVED

New York, N. Y. U. S. A.

St. John's Hospital

Barbours Hotel

St. John's Hospital

Barbours Hotel

Barbours Hotel
St. John's Hospital
New York, N. Y. U. S. A.

Barbours Hotel

St. John's Hospital

55240 JUN -21

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13380

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE P LAST COHEN			2a. DATE OF DEATH MONTH MAY 23, 1987 DAY 23 YEAR 1987		2b. HOUR 12.35 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 22 YEAR 35		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Billings		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Kirby		13e. STREET ADDRESS / ZIP CODE 511 N. Castle St. 21205			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. 218-32-0177		17. INFORMANT Mr. James Cohen - Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia / Resp arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic lung CA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> , 19 <u>87</u> , to <u>5-23</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5-23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Howard S. Tuch</u>				DEGREE MD		22c. DATE SIGNED 5-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard S. Tuch				22e. ADDRESS JHMI			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-24-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 01 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

053395

1- FOR-
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 3 8 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER FRANKLIN COLE				2a. DATE OF DEATH MONTH DAY YEAR May 05-11-87				2b. HOUR 2:22a M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 11, 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4400 Wentworth Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Eng.		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4400 Wentworth Rd. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Lester Cole				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Essie D Franklin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-03-8189		17. INFORMANT ADDRESS Marjorie Brown Cole 4400 Wentworth Rd, 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a PROSTATIC CANCER, ALZHEIMER'S DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 2:22 P.M. 5 7 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/1/87 to 5/7/87 , that (I) (we) last saw the deceased alive on 5/7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Flynn				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Flynn				22e. ADDRESS 600 N. Wolfe Street Baltimore MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.			
24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr. FH 4101 Edmondson Ave.				25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

2

WATSON BOND



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 8 2

FOR
STATE
REGISTRAR

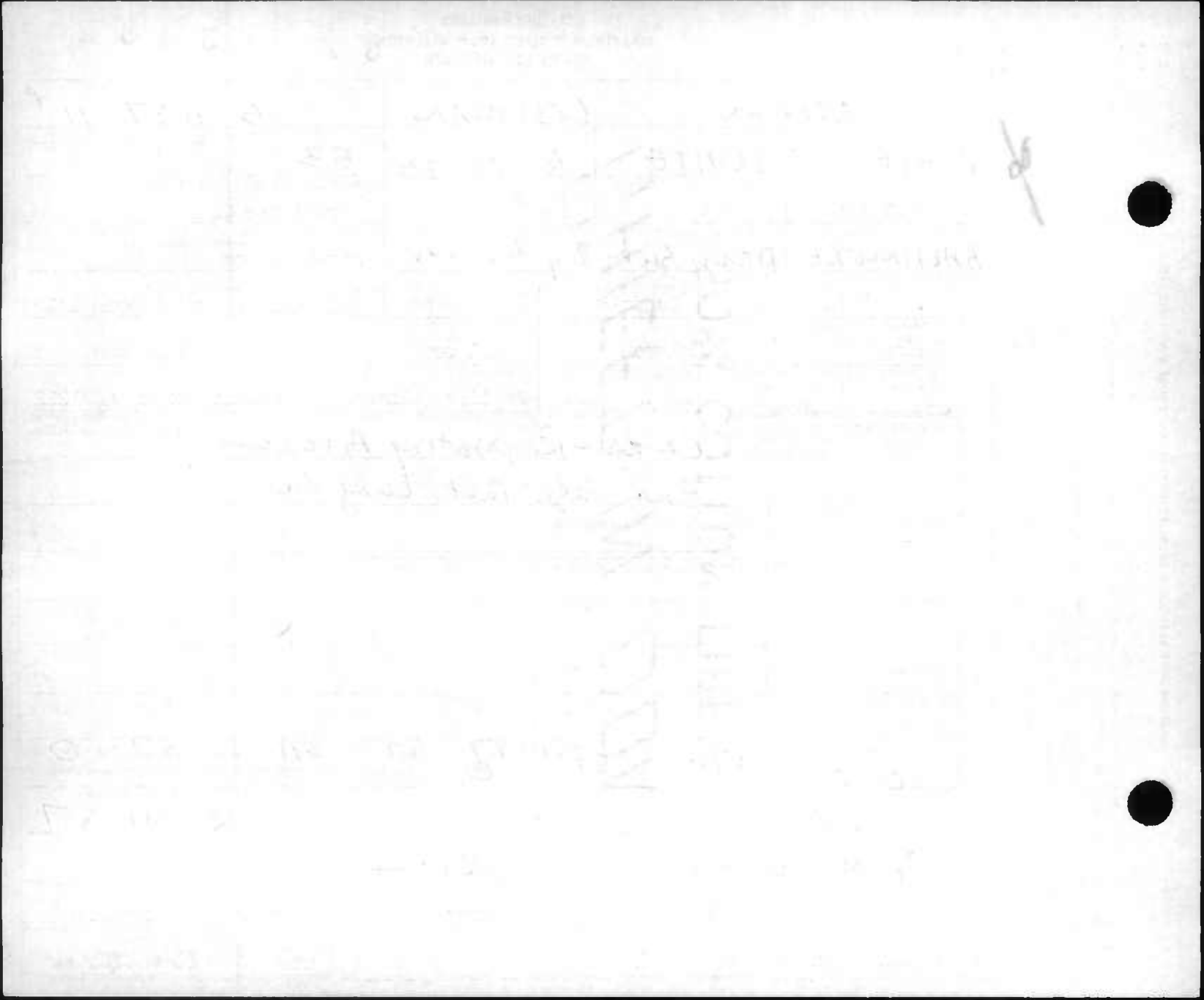
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN COLEMAN			2a. DATE OF DEATH MONTH DAY YEAR 5 11 87		2b. HOUR P 11		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 01 33		6. AGE (IN YEARS LAST BIRTHDAY) 53 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key med Ctr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto,		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Coleman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Wilkinson		17. INFORMANT ADDRESS Phyllis Coleman 3129 Sollers Point Road 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 213-30-1324		17. INFORMANT ADDRESS Phyllis Coleman 3129 Sollers Point Road 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) End stage met. Lung Ca Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/11/87 19 87 , to 5/11 19 87 , that (I) (we) last saw the deceased alive on 5/11 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE WLC		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHIN, LING		22e. ADDRESS FSKMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY OaLawnCemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS ConnellyFuneralHome of Dundalk				25a. DATE REC'D. BY REGISTRAR MAY 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

054399 MAY 25

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SEDELLE COLLIER			2a. DATE OF DEATH MONTH DAY YEAR 5 12 87		2b. HOUR M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 06 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	12b. KIND OF BUSINESS OR INDUSTRY LIQUORS RELIABLE	
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3502 WOODBROOK AVE. BALTIMORE, MARYLAND 21217	
14. FATHER'S NAME FIRST MIDDLE LAST ELIJAH COLLIER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JESSIE LEE WILSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-22-6281	17. INFORMANT ADDRESS MRS. BALTIMORE, MARYLAND EVANAL JEFFERIES 3502 WOODBROOK AVE. 21217			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mins 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>87</u> , to <u>MAY</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Kevin Horgan</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>May 20 87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KEVIN HORGAN</u>	22e. ADDRESS <u>96 Johns Hopkins Hosp N. Wolfe St</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/18/1987	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		
24. FUNERAL HOME NAME 2501 GWYNNS FALLS PARKWAY, BALTIMORE, MD. 21216		25a. DATE REC'D. BY REGISTRAR MAY 21 1987			
		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713384

REG. NO.

1- FOR
STATE
REGISTRAR

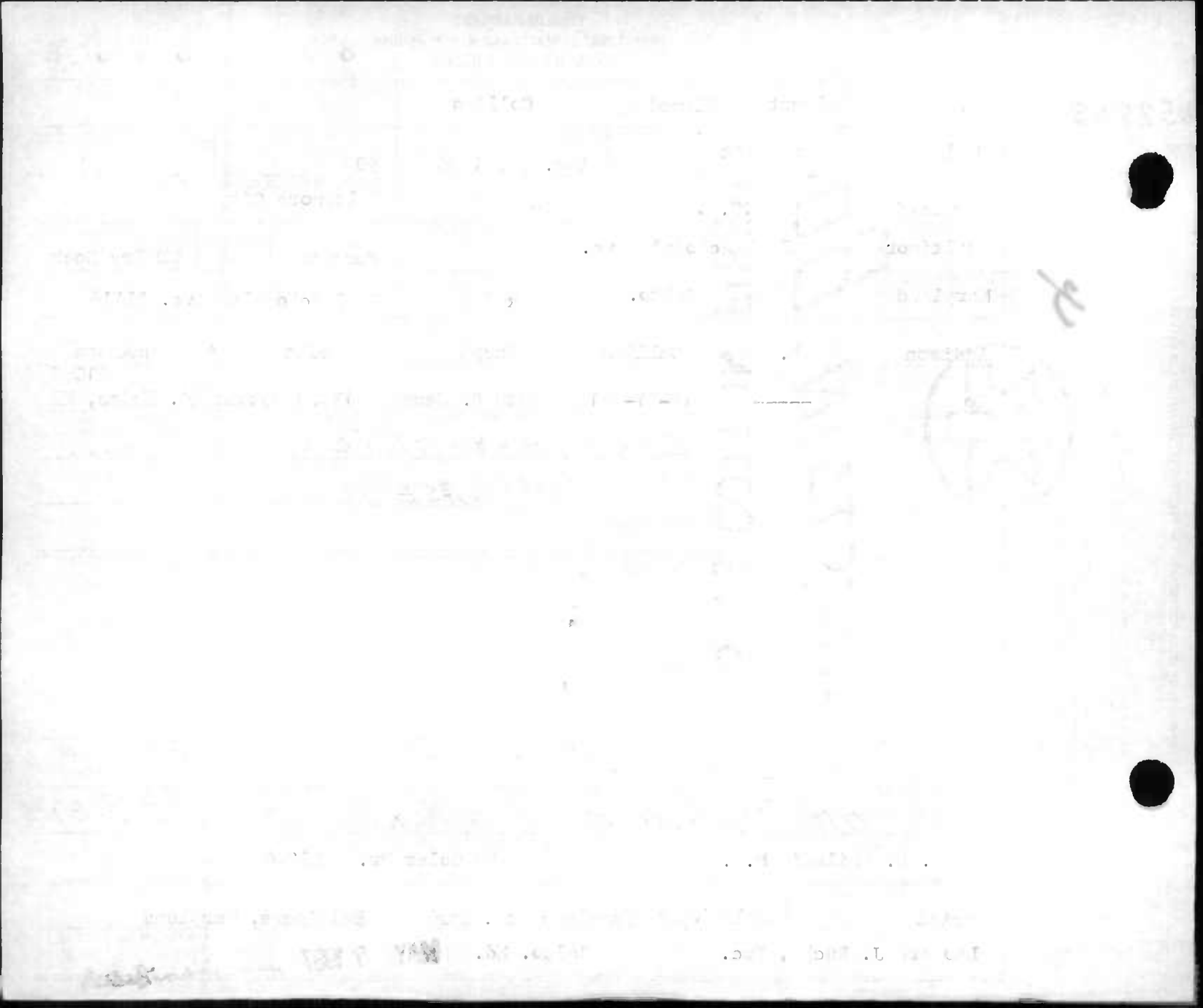
1. DECEASED NAME (TYPE OR PRINT) Albert Elwood Collins			2a. DATE OF DEATH MONTH DAY YEAR 5 5 87		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 3801 Echodale Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY MD Dry Dock
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Addison B. Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Belle unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-8816	17. INFORMANT ADDRESS Ruth D. Newnam 13305 Bottom Rd. Hydes, MD 21082			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> 19 <u>75</u> to <u>3-9</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3-9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>AH Ghiladi M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>5-5-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. H. Ghiladi M.D.		22e. ADDRESS 7600 Osler Dr. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05/07/1987	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md.	25a. DATE REC'D. BY REGISTRAR MAY 7 1987	25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8713385
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Matthew Collins		male		black	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?	
7 30 1930		56 YRS.		U S A	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore City MD.		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland General Hospital		Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE: Md 13b. COUNTY: Baltimore 13c. CITY OR TOWN: Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1819 Etting Street 21217	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Frank Collins		Lila Baker		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
216-28-4358		Viola Collins		1819 Etting Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Overwhelming Staph aureus Sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Status Post Right Pneumonectomy</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemoptysis Right Lung</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<u>Right lung aspergilloma, Chronic Alcoholism</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (x) (this hospital) attended the deceased from <u>March 20</u> , 19 <u>87</u> , to <u>May 6</u> , 19 <u>87</u> , that (x) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>87</u> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (X X X) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Fuad Shihab, M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>FUAD SHIHAB, M.D.</u>		<u>c/o Maryland General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/12/87		Cedar Hill Cemetery	
23d. FUNERAL DIRECTOR		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Wm. C. March F/H West 4300 Wabash Avenue		Anne Arundel Co		Md	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		MAY 12 1987		<u>Lo. Davidson-Randall</u>	

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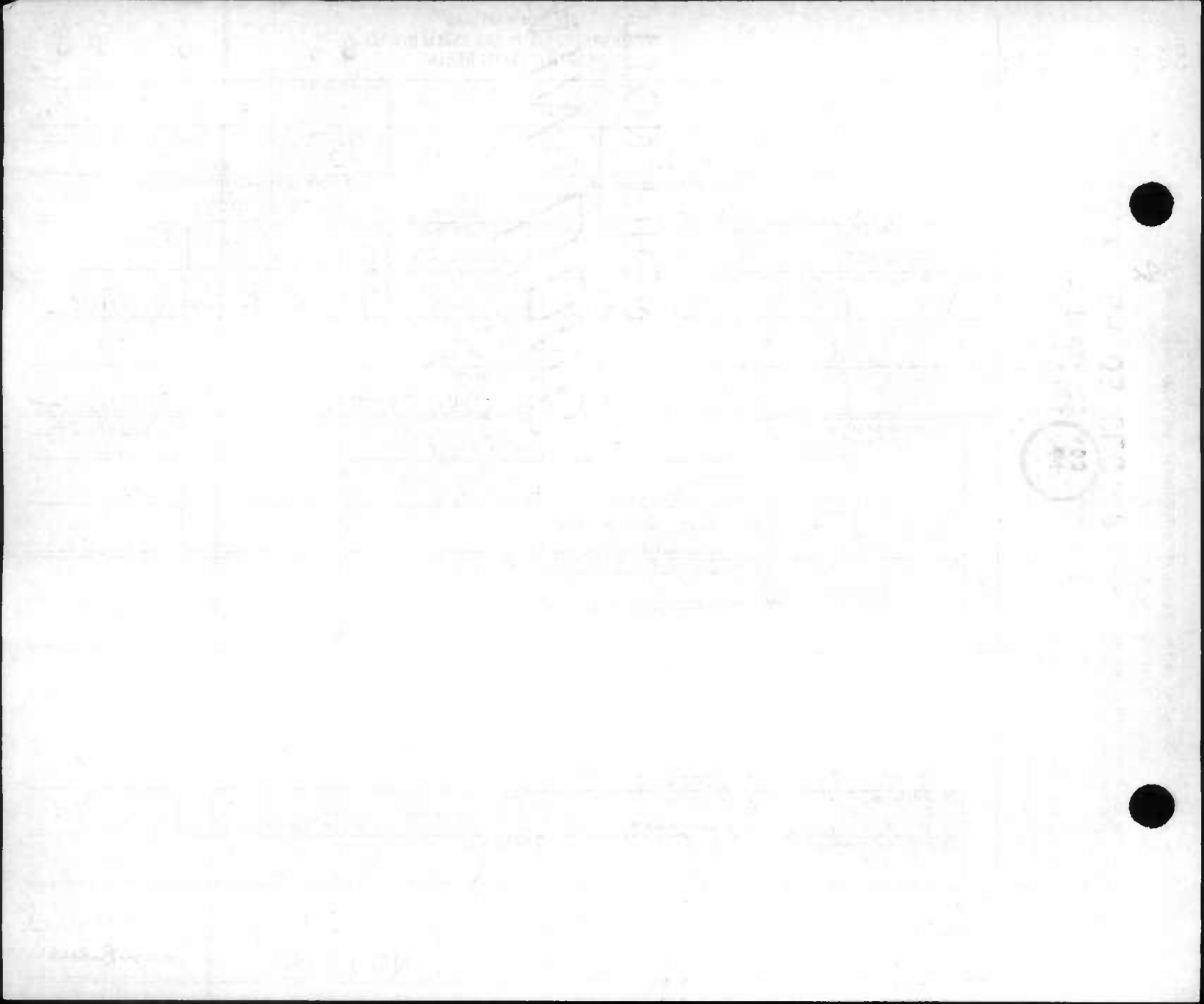
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that 8 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, complete, and sign page 4. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 87 13380				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY C CONIC					2a. DATE OF DEATH MONTH DAY YEAR 5 5 87			2b. HOUR 12 40 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 -13 -1913		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 113 Collington Ave 21231	
14. FATHER'S NAME FIRST MIDDLE LAST Cleveland Conic		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO. 259-10-1712		17. INFORMANT Lottie Mitchell				ADDRESS 105 N. Monroe			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>VENTRICULAR TACHYCARDIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CARDIOMYOPATHY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min. 7 yrs. 10 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hepatoma</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/10, 19 87, to 5/5, 19 87, that (I) (we) last saw the deceased alive on 5/4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.									
22b. SIGNATURE Barry K. Rayburn MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry K. Rayburn				22e. ADDRESS Johns Hopkins Hosp. 600 N WOLFE ST					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-11-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Brown/Thompson F.H.				ADDRESS 1913 W. Ba Ho St.		25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Borden-Randall	



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed in the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13381
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEREMIAH N. CONNER		2a. DATE OF DEATH MONTH DAY YEAR 05 08 87		2b. HOUR 10:40 PM	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 09 04 30		6. AGE (IN YEARS LAST BIRTHDAY) 56	IF UNDER 1 YEAR MONTHS DAYS YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Bethlehem	
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2217 Poplar Grove 21216
14. FATHER'S NAME FIRST MIDDLE LAST Noah Conner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leola Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 258-34-5067		17. INFORMANT ADDRESS Sharon Burgess 3736 Bonview Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulm Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Insufficiency 2° Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/7 , 19 87 , to 5/8 , 19 87 , that (I) (we) last saw the deceased alive on 5/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Ram Lal Mittal		DEGREE MD		22c. DATE SIGNED 5/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAM LAL MITTAL		22e. ADDRESS 2600 Liberty Heights Avenue Baltimore, MD 21216			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/87	23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue			25a. DATE REC'D. BY REGISTRAR MAY 12 1987		
			25b. REGISTRAR'S SIGNATURE Kandian Randle		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 13388	
1. DECEASED NAME (TYPE OR PRINT) MARTHA E. CONNER			2a. DATE OF DEATH MONTH DAY YEAR HOUR 5 24 87 6 25 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 08 09	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7b. HOUR 25 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line		12b. KIND OF BUSINESS OR INDUSTRY Model Toys
13a. STATE Maryland		13b. COUNTY =====	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Conner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth =====			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 213-12-4870	17. INFORMANT ADDRESS Gail Reinhardt 3716 8th Street Balto Md 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) probable hepatic cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/12 19 87 to 5/24 19 87 that (I) (we) last saw the deceased alive on 5/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
22b. SIGNATURE R M Anthenelli MD		DEGREE		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Anthenelli MD		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/29/87	23c. NAME OF CEMETERY OR CREMATORY Hoggard Memorial Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Lewiston Bertie N.C.	25a. DATE REC'D. BY REGISTRAR MAY 28 1987	
24. FUNERAL DIRECTOR George J. Gonca 4001 Ritchie Hwy Balto Md		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The permit should be filed with the funeral director. Page 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to the funeral. The funeral director should file a copy of this certificate with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or other event, the Medical Examiner must be notified and a report filed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13389

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BABY GIRL COOK			2a. DATE OF DEATH MAY 15, 1987		2b. HOUR 7:32 AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH May 15 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Calvert	13c. CITY OR TOWN Sunderland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Hawkins, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Claudette Cook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. --		17. INFORMANT Irving Cook, Jr. P.O. Box 189 Sunderland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF (b) UPPER AIRWAY DEFORMITIES DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE CONGENITAL ANOMALIES						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11c						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from MAY 15, 19 87, to MAY 15, 19 87, that (I) (we) last saw the deceased alive on MAY 15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE William G. Keyes				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-15-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM G. KEYES				22e. ADDRESS JOHNS HOPKINS HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Bethel Way Of Cross Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Huntingtown Calvert Md
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				25a. DATE REC'D. BY REGISTRAR MAY 21 1987		
				25b. REGISTRAR'S SIGNATURE Julia P. [Signature]		

BP

12 12 12



12 12 12



054269 MAY 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	1	3	3	9	0
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BROOKE S. COOK							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/ 18/ 19 87		2b. HOUR AM PM A M						
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/22/15		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 71		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 7:50		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/ 18/ 1987		7d. HOUR AM PM A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 119 Taplow Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 119 Taplow Rd., 21212							
14. FATHER'S NAME FIRST MIDDLE LAST Dunbar S. Sanner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elise Brooke											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 05 1378		17. INFORMANT ADDRESS Grafflin Cook, Jr., Same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fractured Hip and Arthritis															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH ? P.M. 5/ 18/ 87				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/ 18/ 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject inhaled exhaust fumes from auto							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) garage				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 119 Taplow Rd., Baltimore City, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 5/18/87							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth M.D.				ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/19/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD							
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.						25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							
4905 York Road Balto., MD 21212															

07/84
25M

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DHMH - 17
(VR A15 ME (5))

100-3

11 MAY 1961

U.S.

FOR THE DIRECTOR

11 MAY 1961

RE: [illegible]

11 MAY 1961

11 MAY 1961

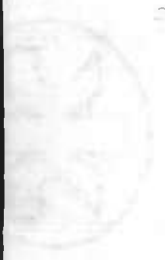
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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 7 1 3 3 9 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) DAVID A. COOK					2a. DATE OF DEATH MONTH DAY YEAR 5 26 87 2b. HOUR 9:40 AM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 03 14 41		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Shock Trauma				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) custodian		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Friendship		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2725 RT 32 21794	
14. FATHER'S NAME FIRST MIDDLE LAST Elroy Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Groom		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 220-36-8098		17. INFORMANT ADDRESS Mr. & Mrs. Elroy Cook, Sr. West Friendship, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Necrotizing fasciitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION 4/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Necrotizing fasciitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4/21/87 to 5/26/87		22a. I certify that (I) (this hospital) attended the deceased from above (I/we) (did) (did not) view the body after death.			
22b. SIGNATURE Leo I. Stemp MD		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo I. STEMP M.D.		22e. ADDRESS Univ of Maryland Shock Trauma Center.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05-30-87		23c. NAME OF CEMETERY OR CREMATORY BUSHEY PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE COOKSVILLE HOWARD MD			
24. FUNERAL DIRECTOR NAME ADDRESS HAIGHT FUNERAL HOME SYKESVILLE, MD		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Sinden-Rudolph					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13392

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME ALFRED FENIMORE COOPER				2a. DATE OF DEATH MONTH DAY YEAR 05-01-87		2b. HOUR 4:55 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper/Salesman		12b. KIND OF BUSINESS OR INDUSTRY Meat Co.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2820 Pelham Ave., 21213		14. FATHER'S NAME FIRST MIDDLE LAST James Fenimore Cooper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna May White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-0421		17. INFORMANT ADDRESS Mary K. Cooper, Dghtr, same as above			
18. CAUSE OF DEATH (Enter only one cause pending for autopsy and PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO- DUE TO, OR AS A CONSEQUENCE OF VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1/87 to 5/1/87 that (I) (we) lost 5/1/87 saw the deceased die on 5/1/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE RIVERA DEGREE MD 22c. DATE SIGNED 5/1/87							
22d. PHYSICIAN'S NAME (GIVE OR PRINT) RIVERA				22e. ADDRESS 5714 HARFORD RD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/4/87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 211				25a. DATE REC'D. BY REGISTRAR 6/1987 25b. REGISTRAR'S SIGNATURE			

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WATER FOR THE DISTRICT

WATER FOR THE DISTRICT

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WATER FOR THE DISTRICT

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713393

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES		FIRST Charles MIDDLE William LAST Copper Jr.		2a. DATE OF DEATH MONTH DAY YEAR 5 19 87		2b. HOUR 3 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 22 37		6. AGE (IN YEARS LAST BIRTHDAY) 50	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City Balto. City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F. LORD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Eastern Stainl.	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Eastpoint		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Charles MIDDLE William LAST Copper Sr.		15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Tribull		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 219-32-5842		17. INFORMANT ADDRESS Ruth Z. Copper 7748 Wynbrook Rd. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/13 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/13 19 87 , to 5/19 19 87 , that (I) (we) last saw the deceased alive on 5/13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William B. Green		DEGREE 2		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM B. GREENOUGH		22e. ADDRESS 5000 EASTERN AVE.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13394

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harry W. Corbin Sr.			2a. DATE OF DEATH MONTH DAY YEAR 5 - 16 - 87			2b. HOUR 8:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 - 11 - 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key M.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3807 Gough Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST William Corbin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Blackwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-16-6473		17. INFORMANT ADDRESS Judith Laurenco 1519 Leslie Rd. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD (CHF)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8:00 AM									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (we) (hospital) attended the deceased from <u>5/16</u> , 19 <u>87</u> , to _____, 19 _____, that (I) (we) lost saw the deceased alive on <u>5/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paw Waller Jr</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paw Waller Jr</u>				22e. ADDRESS <u>1012 Old North Point Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 - 19 - 87		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR Joseph N. Zannino Jr. 263 South Conkling St.				25a. DATE RECD. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Rudner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7 - 1 - 7

Corbin

Barry

75

11 - 11 - 11

Price

512

Washington City

X

U.S.A.

Virginia

Special Worker

Special Agent

Special Agent

Special Agent

Special Agent

Special Agent

Blackwell

Field

Corbin

William

Special Agent

5

George

Special Agent

Special Agent

Special Agent

Special Agent

2122

Special Agent

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. HAVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH RECORDS. PW. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. FREDERICK STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13395	
1. DECEASED NAME (TYPE OR PRINT) Lorraine Cotton					2. DATE KNOWN OF DEATH ESTIMATED 5/17/1987					24. HOUR 11:15 P	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 4 32		6. AGE (IN YEARS) (LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 5/17/1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 229 N. Mount St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2115 Ridgehill Ave 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Wyatt Everett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-36-6166			17. INFORMANT Joseph Everett			ADDRESS 3221 Mondawmin Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF: (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Ethanolism											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described herein, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Signature: Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5/18/87											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/21/87		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H West 4300 Wabash Ave.					25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall				

055740 JUN

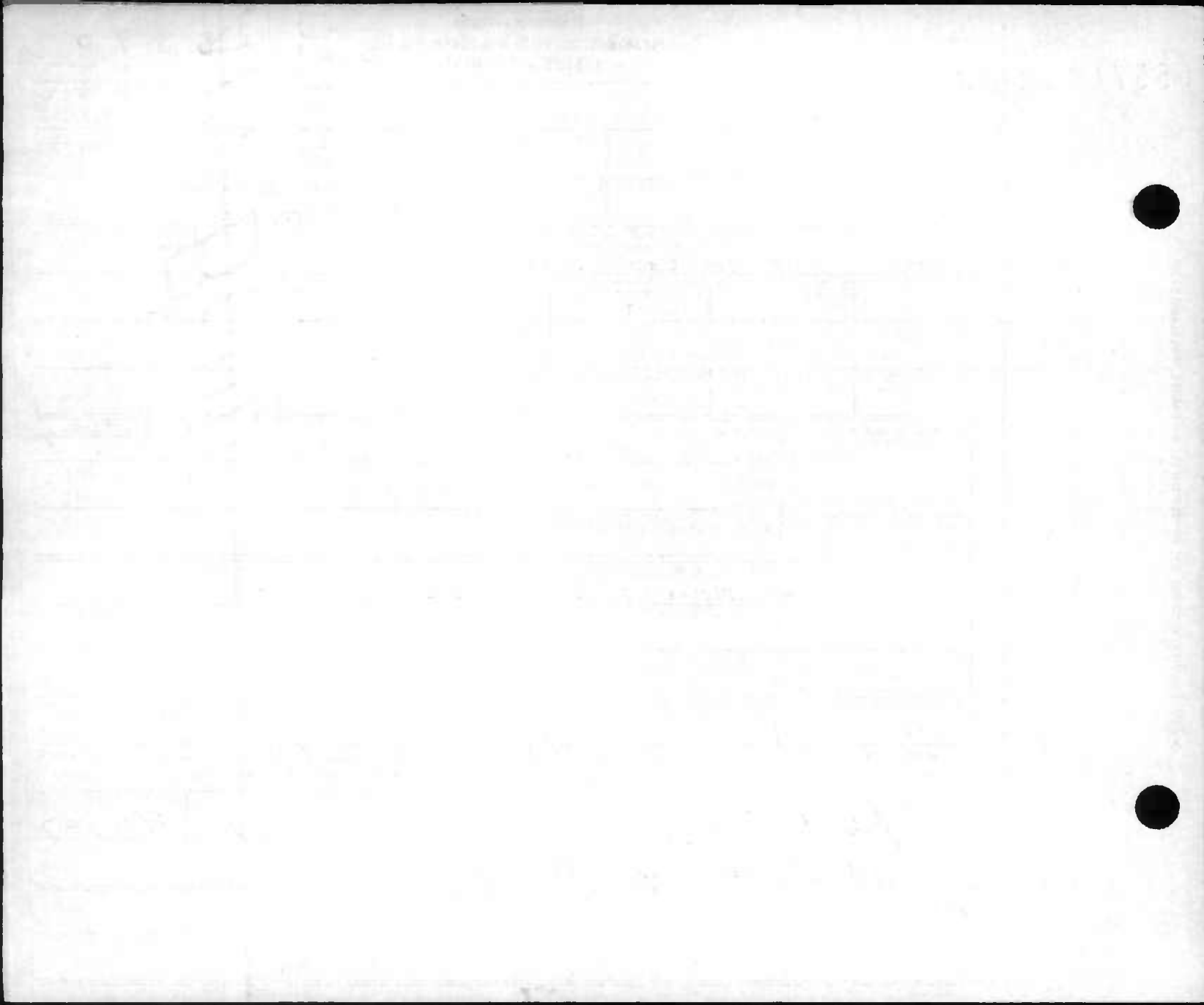
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 1 3 3 9 6

1-DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
Lloyd		Cumbo		May		31 1987		3:15A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		MONTH DAY YEAR 4 2 20		67 YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		USA				Baltimore, City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital				Amtrax			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE					
FIRST MIDDLE LAST William Newsome		FIRST MIDDLE LAST Gertrude Coumbo		5503 Bowleys Lane 21206					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
Yes		239-20-4742		Jannie Jones 5503 Bowleys Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Plumonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Possible Sepsis, Diabetes Mellitus, Chronic Renal Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 28</u> 19 <u>87</u> , to <u>May 30</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 30</u> 19 <u>87</u> , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Yuh-chou Huang</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Yuh-chou Huang MD</u>						22e. ADDRESS <u>C/O Maryland General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>6/5/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest VA</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Owings Mills MD</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H 1101 E. North Ave.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Juanita Gordon-Randall</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713397

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
BONNIE LEE CRAWFORD								5/13/87								3:44 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
FEMALE		WHITE		6 28 49		37		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		South Baltimore general Hosp.		Homemaker		--											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4203 Grace Court		21226							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
Walter L. Wagner		Phyllis E. Souder															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		214-50-8881		George H. Crawford		4203 Grace Court		21226									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIO PULMONARY ARREST															
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		S/12 19 87		S/12 19 87		S/13 19 87		S/13 19 87		S/13 19 87		S/13 19 87		S/13 19 87		S/13 19 87	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
Jerry Lail MD				5/13/87													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
TERILY LAMB MD		506H		347-3200													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		5/15/87		Meadowridge Mem. Pk.		Elkridge		Howard		Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Hubbard Funeral Home, Inc.		21229		MAY 15 1987		R. Lail											
4107 Wilkens Ave.																	

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[Faint, illegible text and markings are visible across the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 3 9 8

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		5/13/87		13 57 4:27 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
male		caucasian		MONTH DAY YEAR		7. AGE (IN YEARS LAST BIRTHDAY)	
				1 27 32		55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A.				Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University Hospital Univ. of Md.		marina oper.		self employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Queen Anne		Chester		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Rt. 1 Box 286 21619			
Dewey L. Critzer		Lottie Carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
yes		Korean		216 28 7870		Gary S. Critzer 588 C. Renee Dr. Joppa, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>RIGHT VENTRICULAR FAILURE</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>MYOCARDIAL INFARCTION</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CORONARY ARTERY BYPASS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
5/11/87		ACUTE MYOCARDIAL INFARCT		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>87</u> , to <u>5/13</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>[Signature]</u>		MD				5/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
STEVEN WEISS		22 S. GREENE ST. BALTIMORE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
burial		5/16/87		Crownsville Vet. Cem		Crownsville Anne Arundel Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		MAY 18 1987		<u>[Signature]</u>			
Gary L. Kaufman 5695 Main St., Elkridge, Md. 21227							

SECRET

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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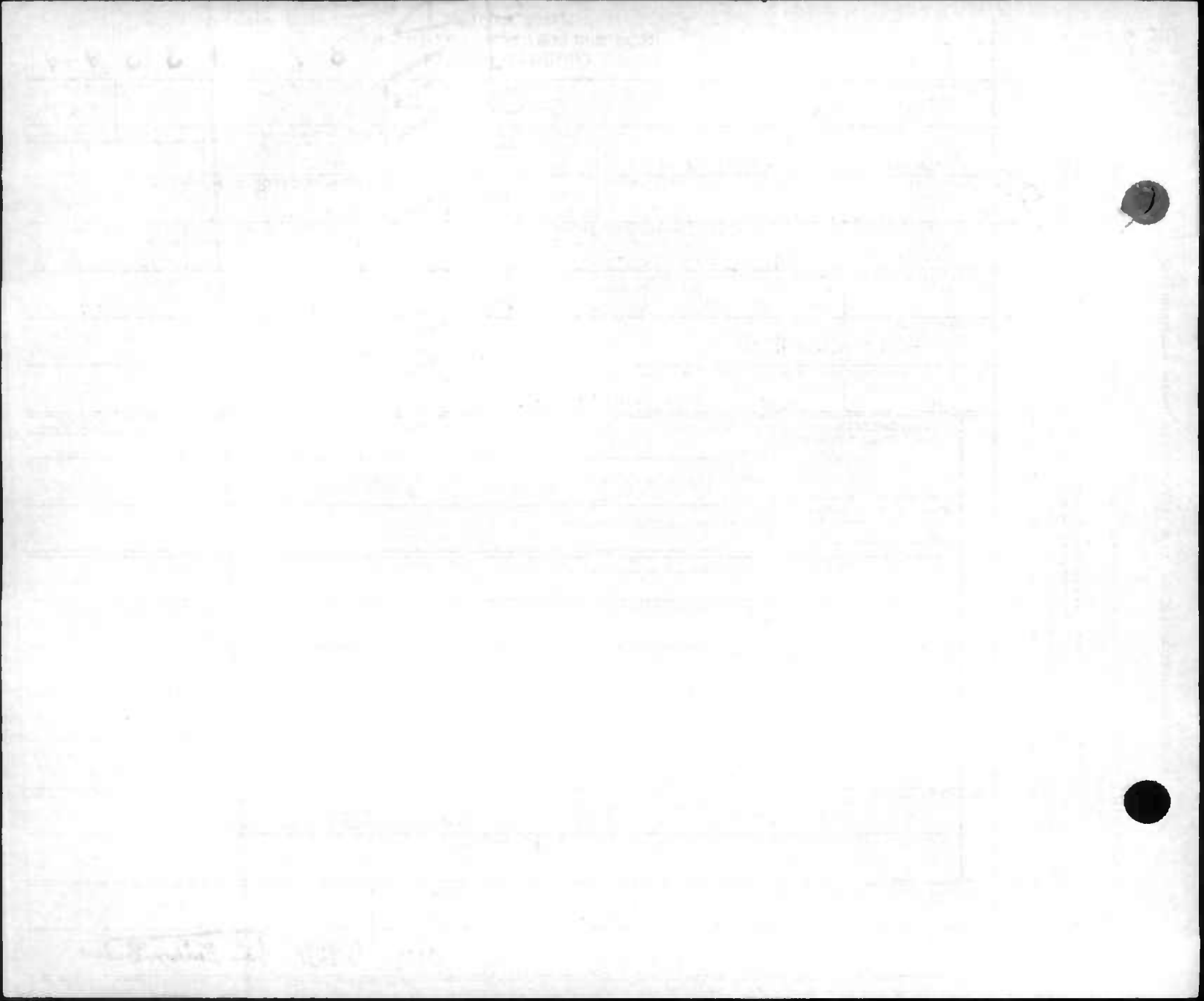
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8713399
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE CROCKETT			2a. DATE OF DEATH MONTH DAY YEAR 5/6/87			2b. HOUR MIN. 12:25 PM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1894		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 92		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Blackstock, S.S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		
12b. KIND OF BUSINESS OR INDUSTRY N/A		13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2518 OSWEGO AVE. 21217						
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT ROBINSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN DEWEISE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS MINNIE C. WHITE 2009 BRYANT AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Sidney J. Ch...		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD A. CUTRO		22e. ADDRESS LIBERTY MEDICAL CENTER						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/9/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HEIGHTS				25a. DATE REC'D. BY REGISTRAR MAY 8 1987 Julia Anderson-Randall				

BP _____



054000 JUN 1987

(3)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

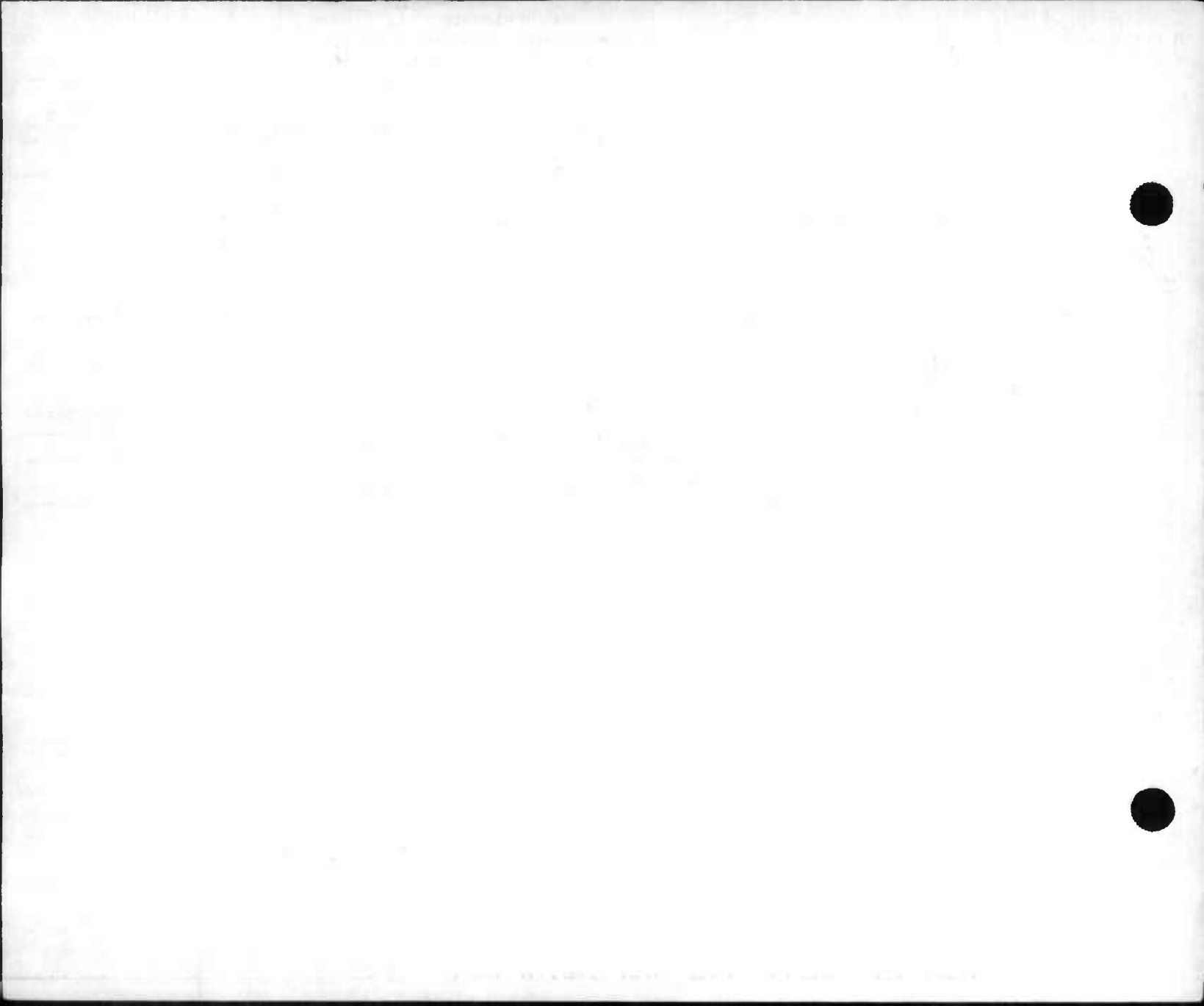
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 13400	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DELORES CROVELL						2a DATE OF DEATH MONTH DAY YEAR 5 24 87		2b HOUR 5:40 AM			
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 8 12 37		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 50		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1016 N. Washington St. 31205			
14 FATHER'S NAME FIRST MIDDLE LAST Eddie Crovell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Riddick		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO							
		16b SOCIAL SECURITY NO. 213-36-2899		17 INFORMANT ADDRESS James Crovell 4422 Wrenwood Ave. 21212							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic CA of Lung DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.											
22b SIGNATURE Kang Sun Lee				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5/29/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) KANG SUN LEE				22e ADDRESS 100 N. Broadway CHURCH HOSPITAL							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/29/87		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDELL Co. MD.					
24 FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E North Ave.		25a DATE REC'D. BY REGISTRAR MAY 28 1987		25b REGISTRAR'S SIGNATURE			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13401

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ROSA		MIDDLE V.		LAST CULOTTA		2a. DATE OF DEATH MONTH DAY YEAR 5-3-87		2b. HOUR 9 ⁵⁶ PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-9-01		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife at home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 811 Scott Street - 21230			
14. FATHER'S NAME FIRST MIDDLE LAST SALVATORE VINCI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONGETTA GERRI JEFFRE CONGETTA JEFFRE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Peter A. Vinci 213 RADSTOCK RD. 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>intraabdominal sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>87</u> , to <u>5/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kathryn Smith		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/3/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kathryn Smith		22e. ADDRESS Univ of Md. Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-6-1987		23c. NAME OF CEMETERY OR CREMATORY New Catholic Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore					
24. FUNERAL DIRECTOR NAME John J. Brown & Son, Inc.		ADDRESS Baltimore, Md. 21223		25a. DATE RECD BY REGISTRAR MAY 07 1987		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the above to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

055368 JUN

Items, 18a., & 22a., G-628, 6/10/87, by

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13402

1. STATE Med. Exam., / Gbj.
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Sheena Monique Buckner			MONTH DAY YEAR 5-30 1987			M 5:11 P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Female	Black	MONTH DAY YEAR 05-17-86	LAST BIRTHDAY 1 YRS.	MONTHS DAYS	HOURS MIN	MONTH DAY YEAR 5-30 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
		USA				Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			5300 Leith Road			BABY		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			Baltimore			Crawsmills		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. INSIDE CITY LIMITS?		
FIRST MIDDLE LAST STUART IRVING Buckner			FIRST MIDDLE LAST DIANA JANIE Felicia MACK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO						FELICIA Buckner 10 STRAWHAT		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		DATE SIGNED 5-30-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn St., Balto., MD 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	6-2-87	Mt. Calvary Cem.	Baltimore Maryland
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
BROWN Thompson F.H.	JUN 2 1987		<i>Mia Jordan-Pendall</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25AMBP 618
DHMH - 17
(VR A15 ME (5))

DMC

W

U

C



sent in three

MS

56192 JUN 11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 4 0 3

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 28 1987										2b. HOUR M 5:10A	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gary Cooper										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 28 1987										2d. HOUR M 5:10A	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 28 65		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital (DOA)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD										13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 734 W. Fayette St. 21201					
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Cooper										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Mae Leake											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Bernard Cooper 2832 W. North Ave.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-28- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jail cell				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 401 E. Eager St., Balto. MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 5/28/87							
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.				ADDRESS 111 Penn St. Balto. MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/3/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD											
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.										25a. DATE REC'D. BY REGISTRAR JUN 10 1987				25b. REGISTRAR'S SIGNATURE [Signature]							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))



100-100-100

55040 JUN -2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13404

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Randolph M. Cunningham</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5 24 87</u>		2b. HOUR <u>7:15 AM</u>	
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>2 24 53</u>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>34</u> YRS.		
8. CITY OR TOWN OF DEATH <u>BALTO. CITY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Deaton Hospital & Medical Center</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.		
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Rudolph Brown</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Loretha Cunningham</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>upholstery repairman</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>213-62-0948</u>		17. INFORMANT ADDRESS <u>Loretha Cunningham 2930 Grantley Ave</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Astrocytoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Seizure disorder</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 24 19 85</u> to <u>May 24 19 87</u> that (I) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Wanda Wicks-Davis</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/26/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WANDA WICKS-DAVIS MD</u>		22e. ADDRESS <u>Deaton Medical Center</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/29/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H West</u>		ADDRESS <u>4300 Wabash Avenue</u>		23d. LOCATION CITY OR TOWN COUNTY MD <u>Anne Arundel Co</u>		
25a. DATE REC'D. BY REGISTRAR <u>JUN 1 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Pandey</u>				

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation of the country and the progress of the work during the year, and the second section deals with the specific results of the work.

2. The second part of the report deals with the specific results of the work. It is divided into three main sections: the first section deals with the results of the work in the field of research, the second section deals with the results of the work in the field of education, and the third section deals with the results of the work in the field of social work.

3. The third part of the report deals with the conclusions and recommendations. It is divided into two main sections: the first section deals with the conclusions and the second section deals with the recommendations.

4. The fourth part of the report deals with the financial statement. It is divided into two main sections: the first section deals with the income and the second section deals with the expenses.

5. The fifth part of the report deals with the appendix. It is divided into two main sections: the first section deals with the list of names and the second section deals with the list of references.

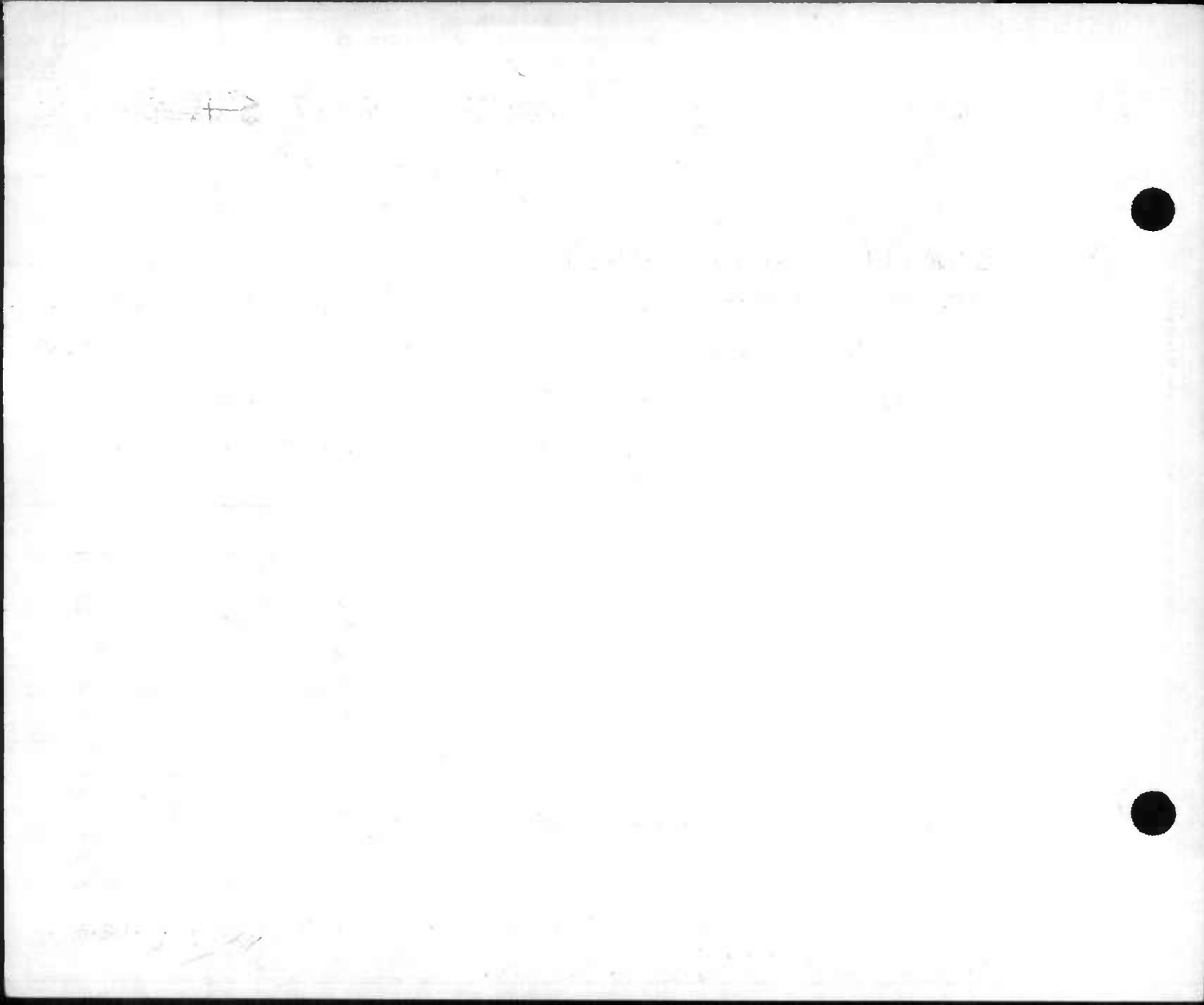
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13405

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AGNES		FIRST L		MIDDLE Cuthbertson		LAST		2a. DATE OF DEATH MONTH 5 DAY 1 YEAR 87		2b. HOUR 11:40 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 16 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Balto. Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY Food Service					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1625 Clarkson St. Balto. Md. 21230			
14. FATHER'S NAME FIRST William MIDDLE ---- LAST Ellis		15. MOTHER'S MAIDEN NAME FIRST Essie MIDDLE ---- LAST Corbett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 246-18-1100		17. INFORMANT ADDRESS William Cuthbertson, Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1d DUE TO, OR AS A CONSEQUENCE OF (c) 1d										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ann L. Penno		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/5/1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie COUNTY AA STATE Co. Md.					
24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.		25a. DATE REC'D BY REGISTRAR MAY 6 1987		25b. REGISTRAR'S SIGNATURE Jane Smith-Rodney							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13406
REG. NO.

FOR
STATE
REGISTRAR

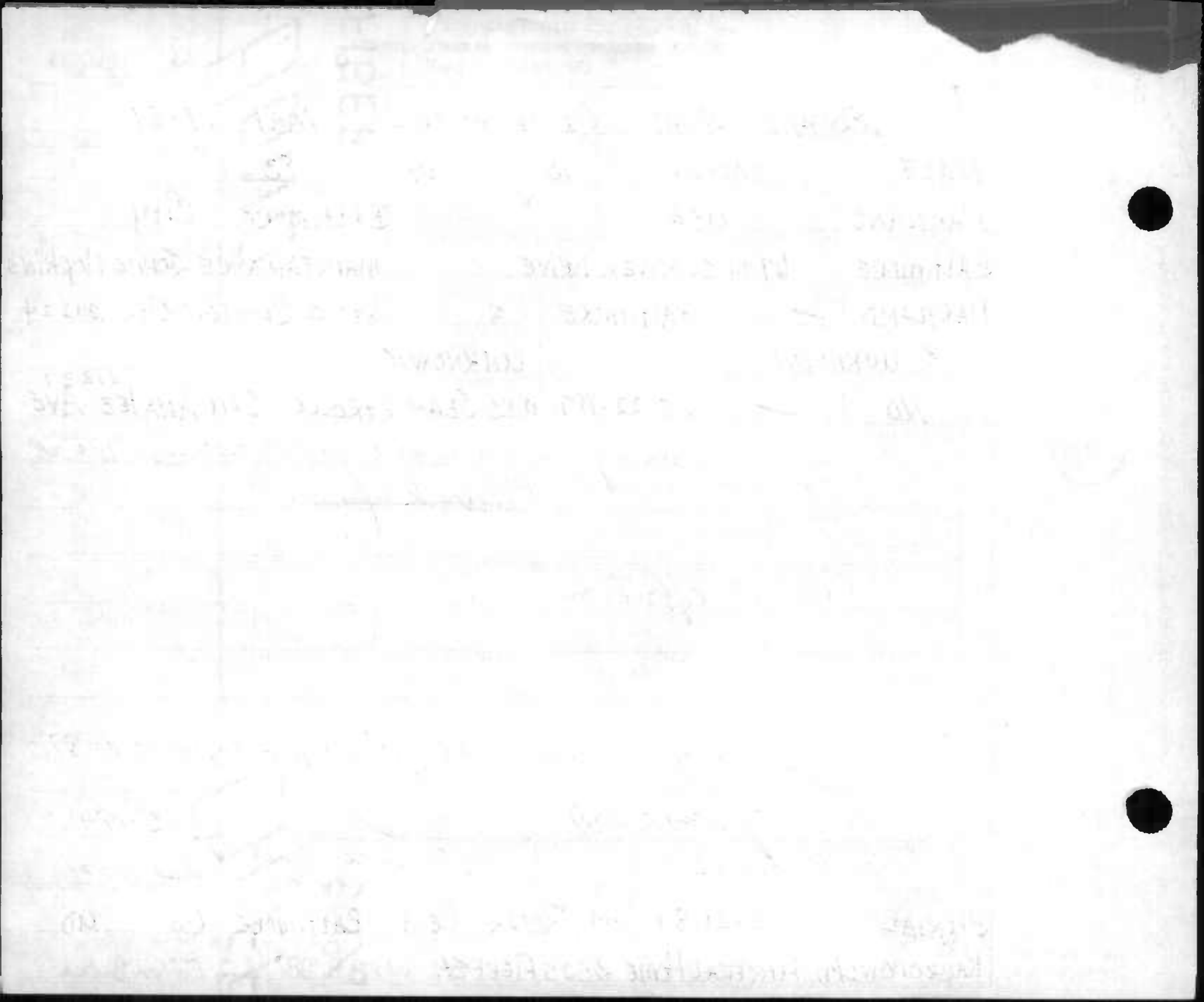
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD JOHN CZYZECHOWICZ			2a. DATE OF DEATH MONTH DAY YEAR MAY 17 87		2b. HOUR M
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 10 19 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6794 S. RIVER DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY JOHNS HOPKINS
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6240 S. CLINTON ST. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST ? UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-22-7891		17. INFORMANT ADDRESS MRS JEAN STROLLE 8211 ANALEE AVE 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lung carcinoma with metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pleural effusion					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from seen at Johns Hopkins Hospital 5-10-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leopoldo Carras M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEOPOLDO CARRAS M.D.		22e. ADDRESS 405 Tremblers Run Rd Balto Md 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-21-87	23c. NAME OF CEMETERY OR CREMATORY Holy ROSARY Cem		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Co MD	
24. FUNERAL DIRECTOR NAME ADDRESS Kaczorowski Funeral Home 2525 Fleet St.		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove card number 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

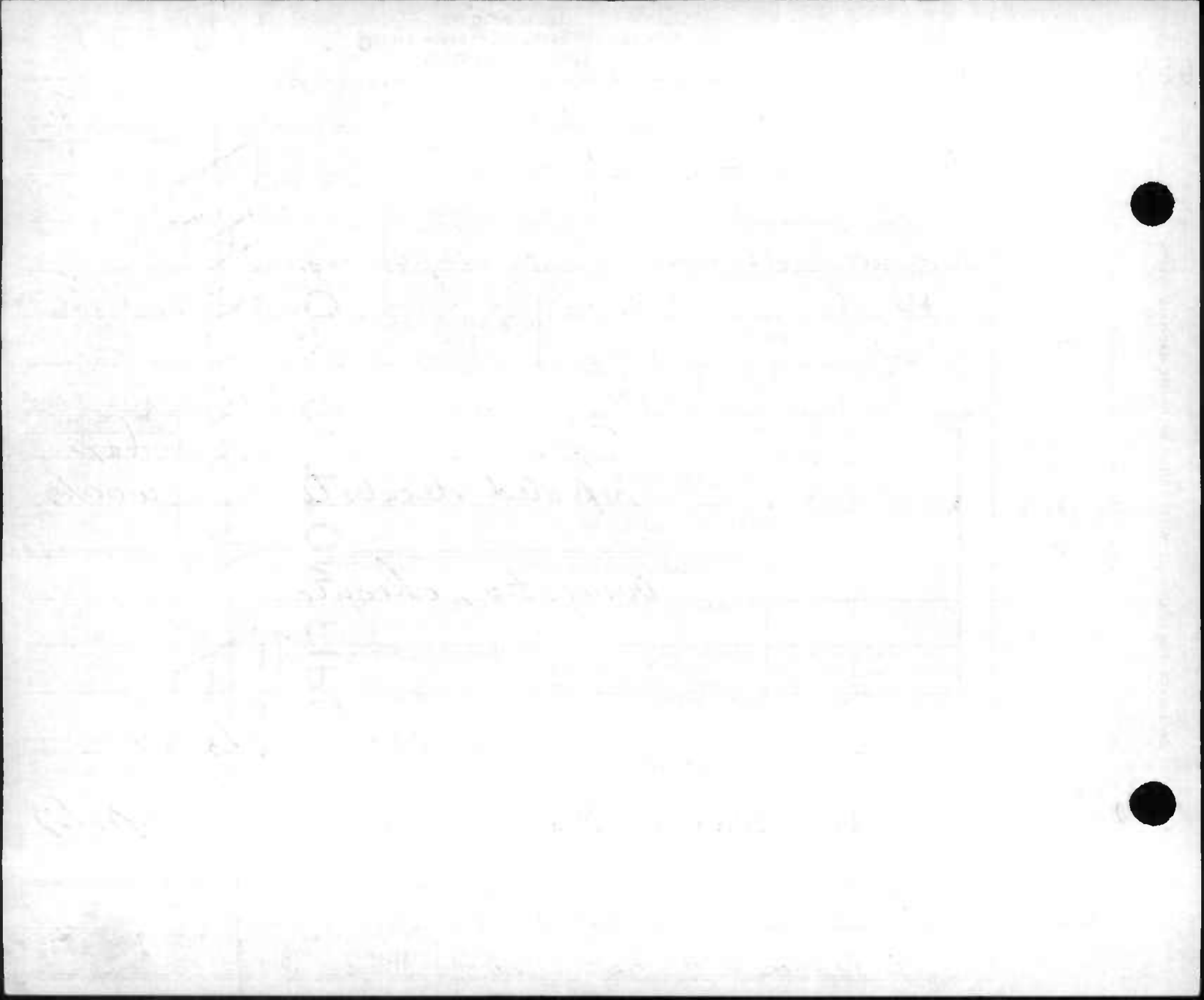
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 13401

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE R. DAILEY			2a. DATE OF DEATH MONTH DAY YEAR 5 25 87		2b. HOUR 6 39 P. M.	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 07 09 11		6. AGE (IN YEARS LAST BIRTHDAY) 75		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JL Deaton Med. Center + Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Willard Dailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie N/A		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-07-0403		17. INFORMANT ADDRESS Dorothea Pitts 3506 Woodland Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) infected decubiti Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) weeks						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia, chronic						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that at this hospital attended the deceased from 5/20/87 to 5/25/87 , that the (we) last saw the deceased alive on 5/20/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dr. Gladen, MD		DEGREE MD		22c. DATE SIGNED 5/26/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-2-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F.H. 4300 Wabash Ave				
25a. DATE REC'D. BY REGISTRAR JUN 2 1987		25b. REGISTRAR'S SIGNATURE John Gordon Kende				



FOR
1- STATE
07 REGISTRAR

REG. NO. 13408

BP_____

DHMH - 17

(VR A15 ME (5))

REPORT NUMBER

100-100000



DATE

100-100000

BY

100-100000

FOR

100-100000

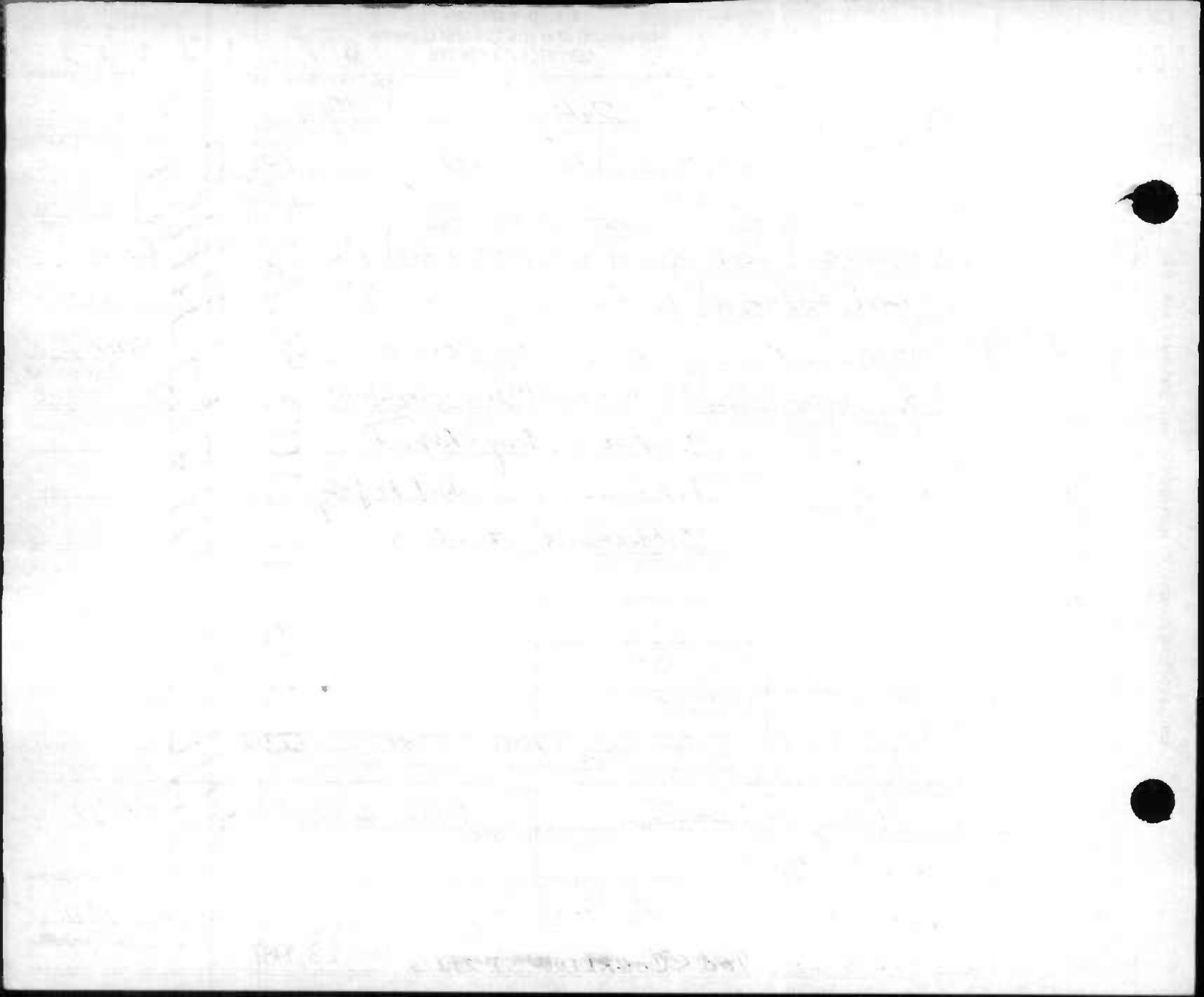
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100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13409
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
William Peter Daley		May 9, 1987		2 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	75 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Loch Raven Veterans Hospital	PUMPMAN	EXXON		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	6503 Moyer Ave 21206		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
James P. Daley		Katherine FISHER Daley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
Yes 5/12/41-11/14/41		215-07-1426	Marie Hohenstein Baltimore		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 9289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Irreversible Cerebral injury</u> (c) <u>Subarachnoid Hemorrhage</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/15/87, 19 87, to 5/17/87, 19 87, that (I) (we) last saw the deceased alive on 5/17, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE			22c. DATE SIGNED
Craig C. B. [Signature]		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			5/17/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Craig A. B. [Signature]					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
BURIAL		May 12, 1987	Parkwood Cemetery	BALTO. MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		MAY 12 1987		[Signature]	
Lilly & Zeiler Inc. 700 S. CONKLING ST. 21224					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713410

1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT		MIDDLE JOSEPH		LAST DALY		2a. DATE OF DEATH MAY 16, 1987		2b. HOUR P 1:05 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 1, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 417 Cedarcroft Rd. 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Dana Daly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Edith C. Daly		ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPSIS</u>										2 WEEKS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL FAILURE</u>										1 WEEK	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PORTAL HYPERTENSION</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> 19 <u>87</u> to <u>5/16</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Julie Livingston MD</u>						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julie Z Livingston						22e. ADDRESS 600 N Wolfe St. Balto 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 20, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md 21212						25a. DATE REC'D. BY REGISTRAR MAY 20 1987		25b. REGISTRAR'S SIGNATURE <u>Julie Livingston</u>			

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, or death, the medical examiner must be notified and signed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove cause of death. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

BP

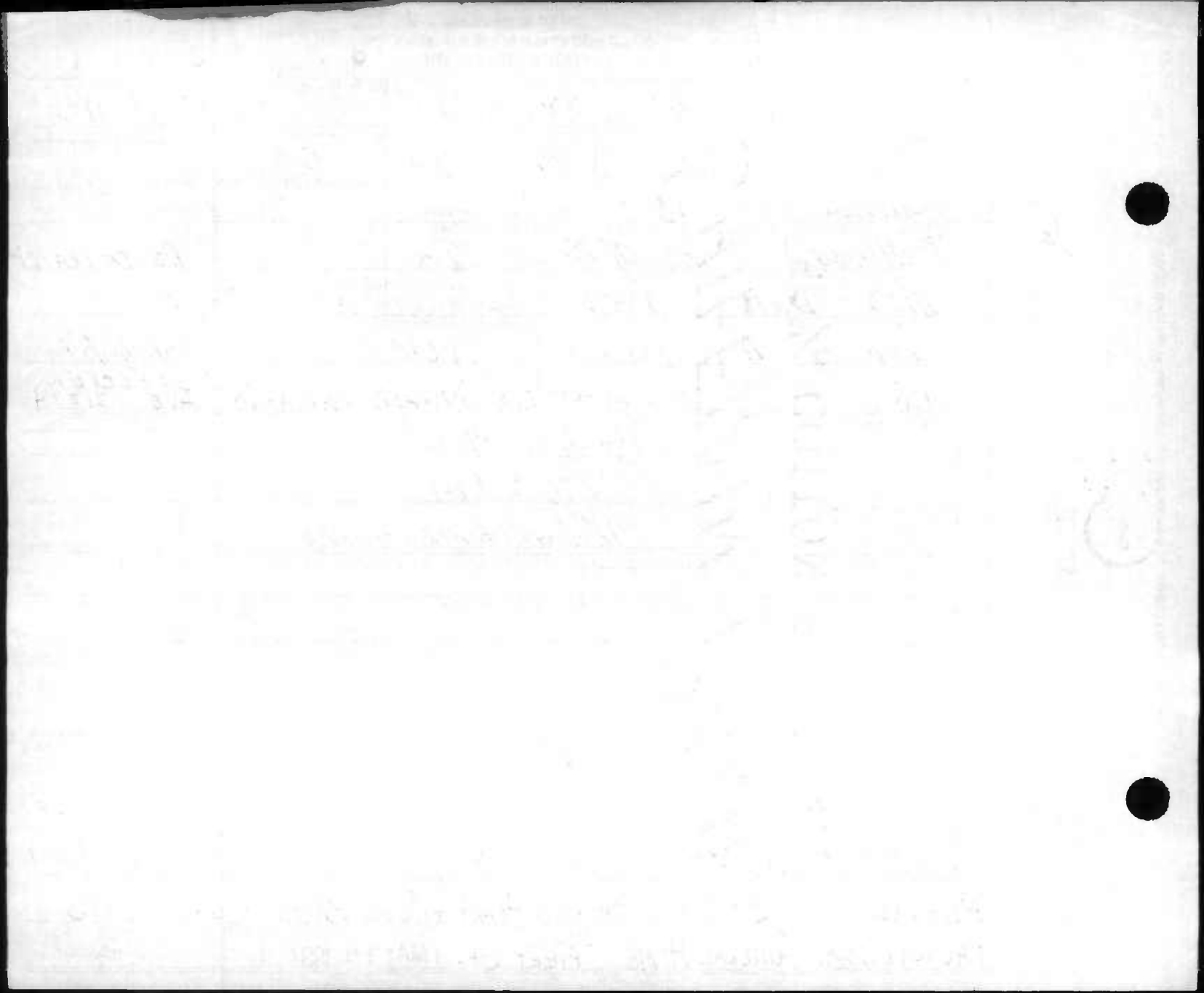
U.S. AIR FORCE
OFFICE OF THE SECRETARY

1

MAY 10 1957

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 4 1 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
LOIS M DAMARIB					05	10	87		11 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	01 11 37		50	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore	USA			Baltimore City MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Univ. of MD CA CTR				RESTAURANT				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE					
MD	Balt	Balt		3132 Foster Ave 21224					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Leo A Fischer		Vera Wiesniewski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
UN		213 34 6099		MR. DONALD DAMARIO		3132 FOSTER AVE 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Immunoblastic lymphoma</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>040187</u> , 19 <u>87</u> , to <u>0510</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>0510</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>051087</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. HUBER</u>		22e. ADDRESS <u>22 S. Annapolis St. Balt MD 21201</u>							
23a. BURIAL, CREMATION, REMOVAL SPECIES <u>BURIAL</u>		23b. DATE <u>5-13-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART & JESUS BALTO Co.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO MD</u>			
24. FUNERAL DIRECTOR NAME <u>KACZOROWSKI FUNERAL HOME</u>		ADDRESS <u>3525 FLEET ST.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 14 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



053226 MAY 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13412

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
EDWARD						DANIELCZYK		<input checked="" type="checkbox"/> ESTIMATED		5		7		19		87					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		White		1 26 1917		70 YRS.		MONTHS		DAYS		HOURS		MIN		5		7		19 87	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Michigan		USA		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		Key Medical Center (DOA)		Forman		Beth. Steel															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1947 Searles Rd.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Julian		Danielczyk		Amelia		Earhert															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No		213-09-2263		Mildred M. Danielczyk		Same as 13e.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b). <u></u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c). <u></u>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
<u>Diabetes mellitus</u>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		5-8-87															
		Deputy Chief																			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., MD		21201															
Ann M. Dixon, M.D.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE									
Burial		5-11-87		Christ Lutheran		Baltimore Maryland															
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Duda-Ruck Funeral Home of Dundalk		MAY 11 1987																			
7922 Wise Ave. Dundalk, MD 21222																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

70% COTTON FIBER

X

055018 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST
CARRIE
(CARRY)

MIDDLE

H.

LAST

DANGERFIELD

2a. DATE KNOWN
OF
DEATH ESTI-
MATED

MONTH DAY YEAR
5 23 19 87

7b. HOUR
M

3. SEX

female

4. RACE

black

5. DATE OF BIRTH

11 16 1926

6. AGE (IN YEARS)

60 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
5 23 19 87

7d. HOUR
M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Md

7b. CITIZEN OF WHAT COUNTRY?

U S A

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3835 Sequoia Ave.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Disabled

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3835 Sequoia Avenue 21215

14. FATHER'S NAME

Robert

MIDDLE

LAST

Garner

15. MOTHER'S MAIDEN NAME

Blanche

MIDDLE

LAST

Greenwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

212-26-0962

17. INFORMANT

Pauline Powell

ADDRESS

3835 Sequoia Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

M.D.

TITLE (SPECIFY)
Deputy Chief

MEDICAL EXAMINER

DATE
SIGNED

5-24-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

5/28/87

23c. NAME OF CEMETERY OR CREMATORY

Garrison Forest Vet

23d. LOCATION
CITY OR TOWN

Owings Mills

COUNTY

STATE

Md

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H West 4300 Wabash Avenue

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JUN 1 1987

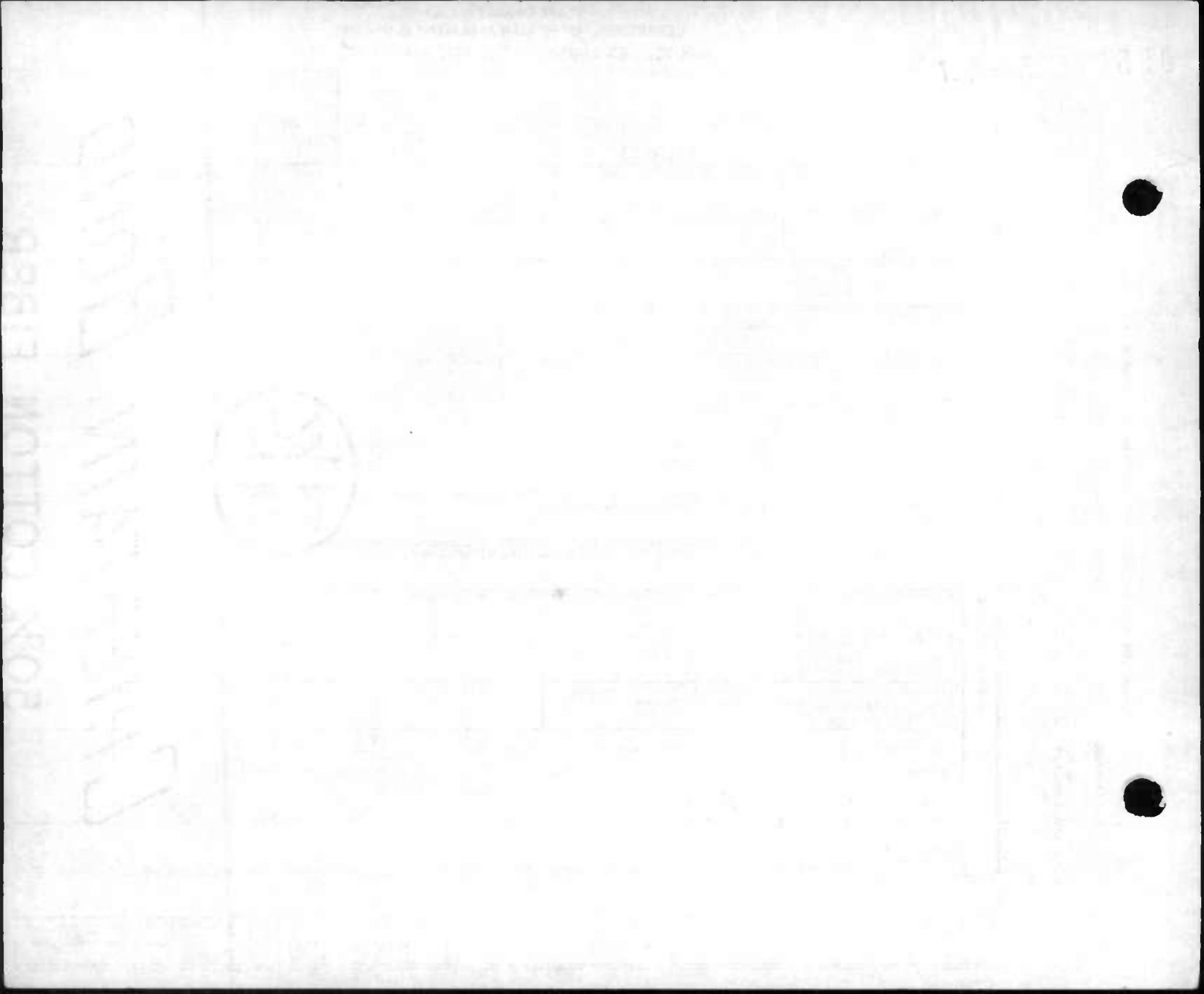
25b. REGISTRAR'S SIGNATURE

Julia Anderson-Randall

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



054701 MAY 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MILDRED MIDDLE VIRGINIA LAST DAUSE		05/22/87		7pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	07/28/1908	78 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	St. Agnes Hospital	HOUSEWIFE			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD	BALTIMORE	CURTIS BAY	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1570 LOCUST ST 21226	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
FIRST MIDDLE LAST WILLIAM UPPERMAN		FIRST MIDDLE LAST CLUES		1570 LOCUST ST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		218-07-5218		EDWARD DAUSE CURTIS BAY 21226	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 9289 Cardio respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Post Traumatic Brain Injury 2 month					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 23 19 87, to May 22 19 87, that (I) (we) last saw the deceased alive on May 22 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
S. S. S.				5/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
SAMER SUKI		5753 RICHARDSON MEWS SQ			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	5-26-87	CEDAR HILL CEMETERY	GLEN BURNIE A. A. C. MD		
24. FUNERAL DIRECTOR					
NAME ADDRESS					
MCCULLY FUNERAL HOME BROOKLYN 21225					
DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE					
MAY 27 1987 Julia J. J. J.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

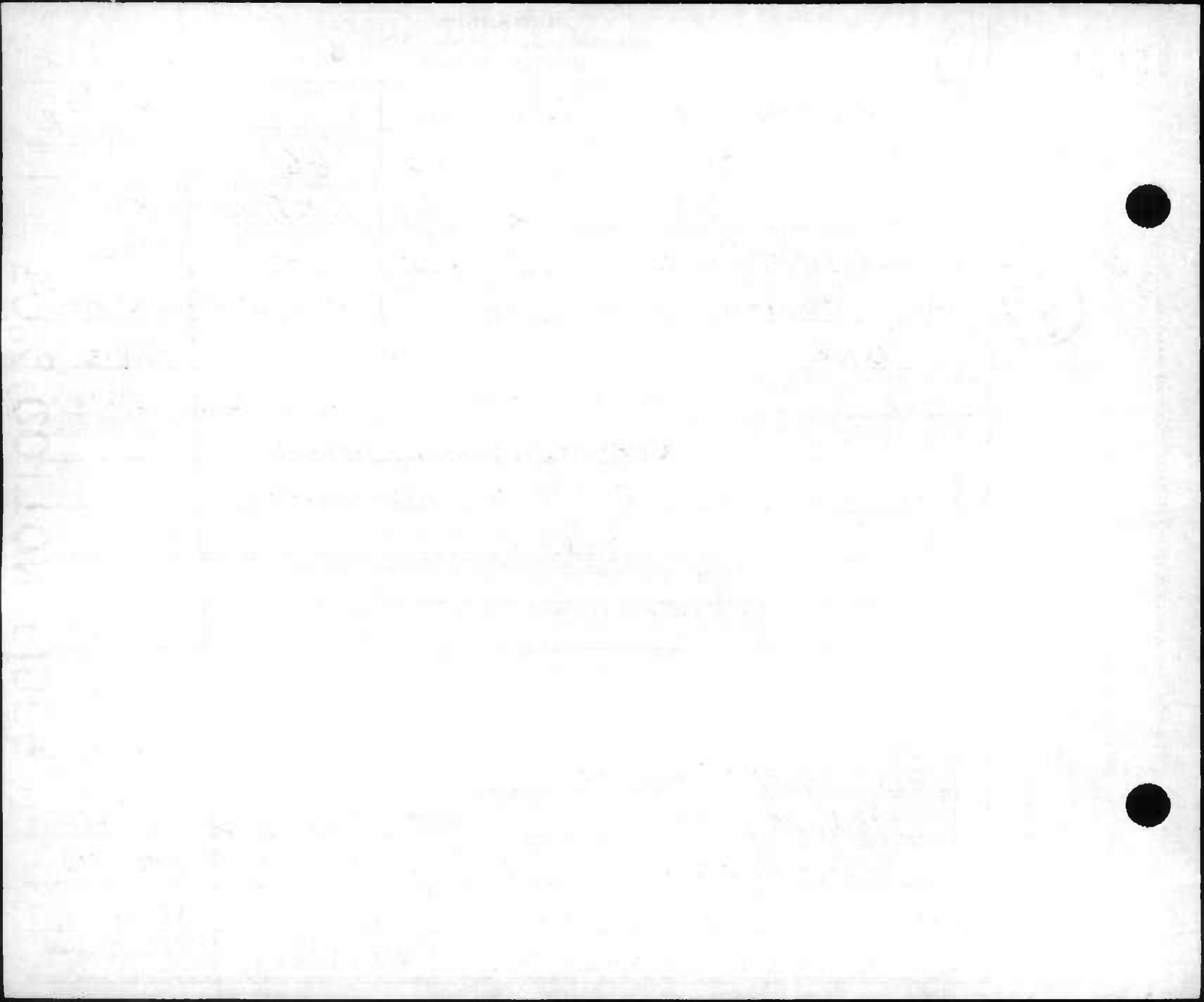
DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLAYTON A. DAVIS, Sr.		2a. DATE OF DEATH MONTH DAY YEAR 05/16/87		2b. HOUR 11:23 M	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 21 20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 512 NORMANDY AVE 21229	
14. FATHER'S NAME FIRST MIDDLE LAST UNK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 21907-7095		17. INFORMANT ADDRESS (SBGH) Jacqueline Bailey 512 Normandy Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BACTERIAL MENINGITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 87 , to 5/16 19 87 , that (I) (we) last saw the deceased alive on 5/16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE —		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick W. W. W.		22e. ADDRESS 3001 S. HANOVER ST. BALT. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet.	
23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.		24. FUNERAL DIRECTOR NAME Wm C March F/H West		25a. DATE REC'D BY REGISTRAR MAY 21 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. ADDRESS 4300 Wabash Ave.			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 1 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD D. DAVIS			2a. DATE OF DEATH MAY 1 1987		2b. HOUR 6:00am
3. SEX Male	4. RACE White	5. DATE OF BIRTH August 3, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Eddco Supply. Ret'd Owner		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN West River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George E. Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Hulseman		13e. STREET ADDRESS / ZIP CODE 826 Locust Drive 20778	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-05-2599		17. INFORMANT Lizetta A. Davis 826 Locust Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 16 19 87 to MAY 1 19 87, that (I) (we) last saw the deceased alive on MAY 1 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Paul Gormley</i>		DEGREE M.D.		22c. DATE SIGNED 5/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL GORMLEY, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-87	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR MAY 4 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Decker-Rudner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked as any injury, or other traumatic event, the medical examiner must be notified at once.

100-25301

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which may be headings or subheadings, but the specific content cannot be discerned.]



054078 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director (page 3) should be detached for use as the burial-transit permit. Then please re-attach carbon page 3. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANIE Mae DAVIS			2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1987		2b. HOUR 11:45A _M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 7-1938		
7a. BIRTHPLACE (COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Private				
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2120 E. Federal St. 21213				
14. FATHER'S NAME FIRST MIDDLE LAST Rich Woodward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah J. Chislow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 249-66-6274		17. INFORMANT ADDRESS 2120 E. Federal St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO, OR AS A CONSEQUENCE OF (b) Liver metastases DUE TO, OR AS A CONSEQUENCE OF (c) Colon cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d 5 months 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 30, 1987, to May 11, 1987, that (I) (we) last saw the deceased alive on 5/11/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Scott Kaufmann M.D.				22c. DATE SIGNED 5/11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT KAUFMANN				22e. ADDRESS 600 N. WOLFE ST. BALTO, MD. 21205		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Crmty.		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.						
24. FUNERAL DIRECTOR NAME Randolph J. Terlick				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		
ADDRESS 2431 E. Oliver St.				25b. REGISTRAR'S SIGNATURE		

BP

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY, N. Y.

1934

44

April 1-1934

Black

White

W. S. B.

W. S. B.

Palmer

Connelly

William W. Woodard

W. S. B.

U. S. Marshal

Woodard

W. S. B.

State of New York

W. S. B.

1934

Palmer

Woodard

W. S. B.

State of New York

052955 MAY 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13418

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruth Davis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 4, 1987</i>		2b. HOUR <i>4:35 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 7 16</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE <i>Maryland</i>		13b. COUNTY -		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Preston</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Victoria Walker</i>		13e. STREET ADDRESS / ZIP CODE <i>830 Chauncey Ave. 21217</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-30-3353</i>		17. INFORMANT ADDRESS <i>Wilson Davis 830 Chauncey Ave. 21217</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 Hours</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>May 3, 1987</i> , to <i>May 4, 1987</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>May 4, 1987</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Christopher Hogan M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>May 5, 1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHRISTOPHER HOGAN</i>				22e. ADDRESS <i>c/o Maryland General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/9/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Owings Mills, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 E. North Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 8 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia B. ...</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

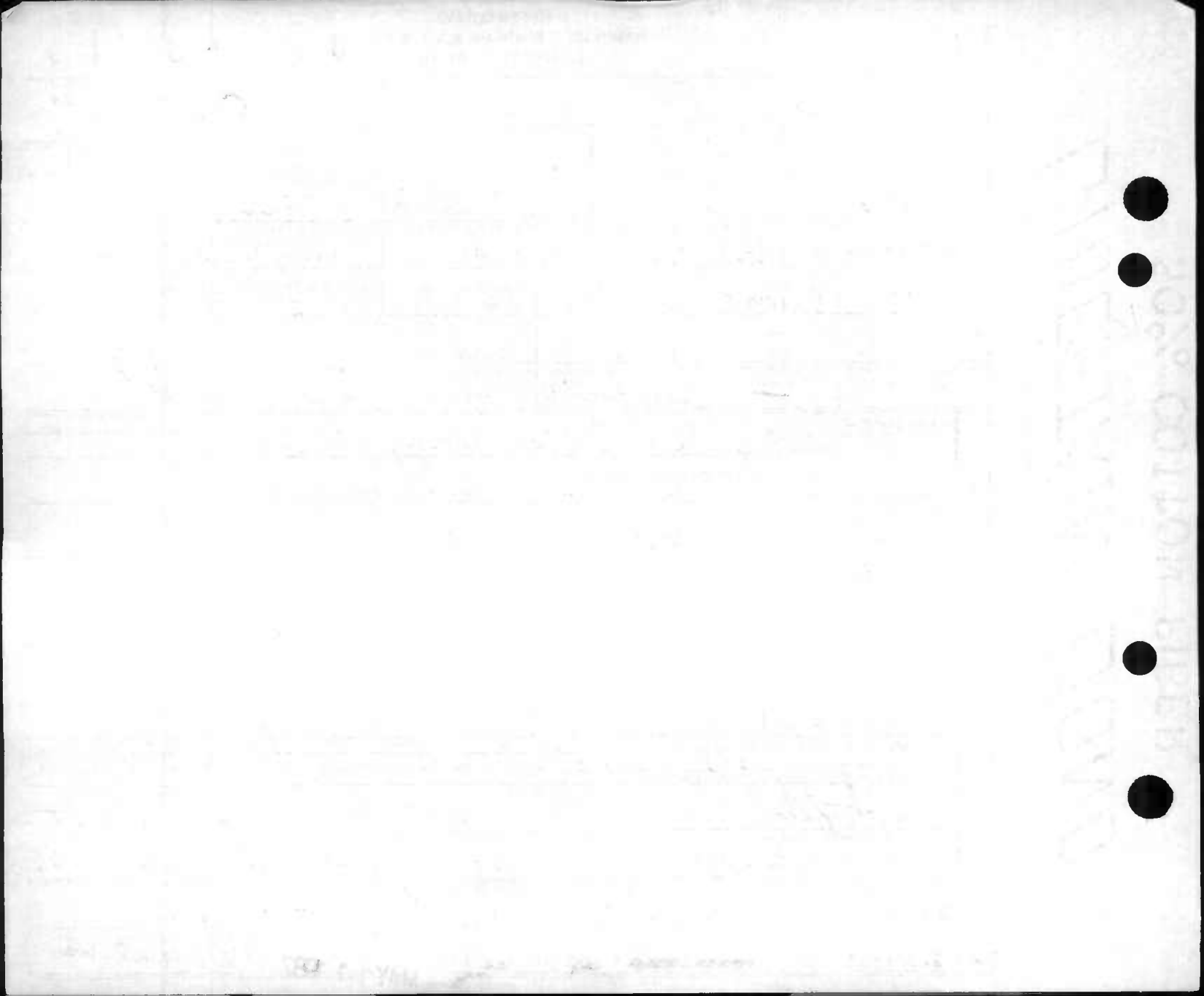
87 13419

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THERON A DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 5-8-87		2b. HOUR 6:27 PM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2 15 57	6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1916 Edmonson Ave / 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Theron A DAVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Gainer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) —		16b. SOCIAL SECURITY NO. 215-70-2948	17. INFORMANT ADDRESS THERON DAVIS AS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Acute Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Sepsis - AIDS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>AIDS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/6/87</u> 19 <u>87</u> , to <u>5/8</u> 19 <u>87</u> , that (I) (we) lost <u>saw the deceased alive on 5/8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Rony Poradowsky</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rony Poradowsky		22e. ADDRESS 2000 West Baltimore Street, Baltimore MD 21223			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 13, 87	23c. NAME OF CEMETERY OR CREMATORY Mt Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md	
24. FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave.		25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP



055101 JUN 20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

13420

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		3 ³⁰ PM	
Baby "B" Boy		5 3 87		3 ³⁰ PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	black	MONTH DAY YEAR	0 YRS.	IF UNDER 24 HRS.	
		5 3 87	0	MONTHS DAYS HOURS MIN.	
			0	0 3 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Sinai Hospital				
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE		
Md		Baltimore	4002 Oswego Ave 21215		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Gregory Wilson		Kimberly DAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Severe Prematurity with					
DUE TO, OR AS A CONSEQUENCE OF Cardio pulmonary Arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-3 19 87, to 5-3 19 87, that (I) (we) lost					
saw the deceased alive on 5-3 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Donna L. Snyder		MD		5-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Donna L. Snyder MD		Sinai Hospital, Balt. Md 21215			
23a. BURIAL CREMATION REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		5-26-87		Sinai Hospital	
23d. LOCATION		23e. COUNTY STATE			
CITY OR TOWN		Baltimore Md			
24. FUNERAL DIRECTOR					
NAME ADDRESS					
Sinai Hospital 2401 W. Belvedere Ave					

MEDICAL CERTIFICATION

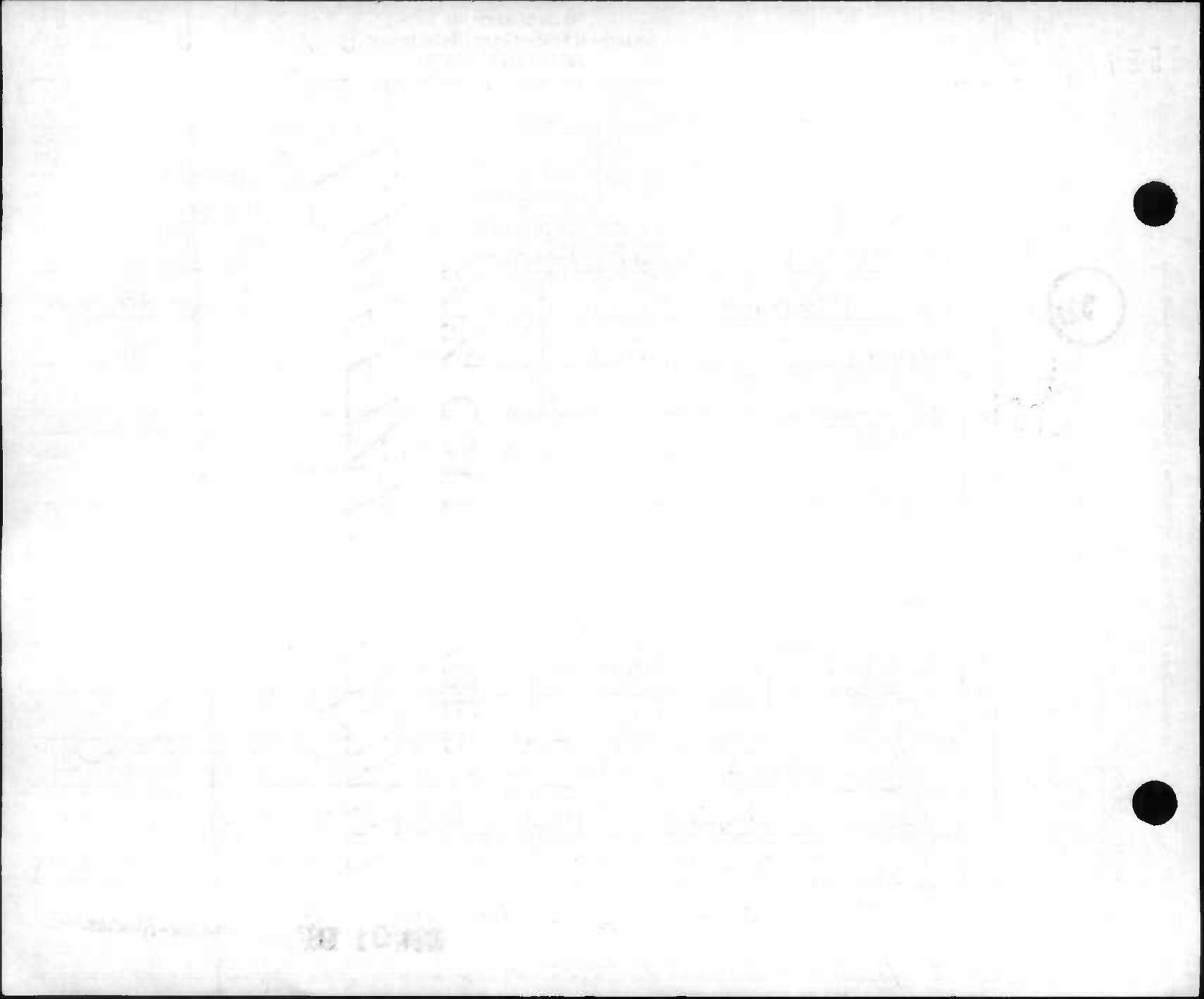
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and committed to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

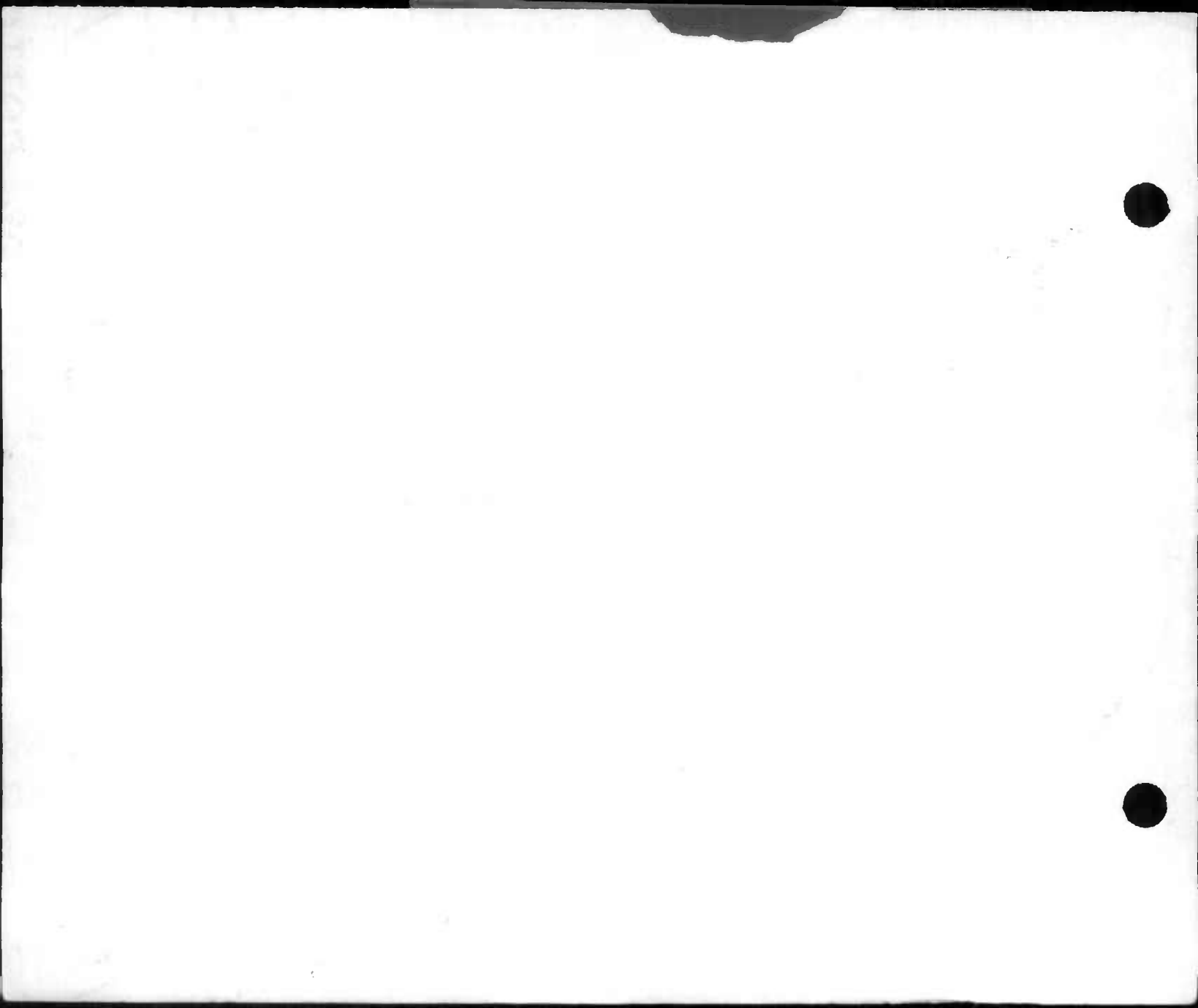
Item 2a
FOR per phone 6/12/87
1. STATE REGISTRAR DDDSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baby Girl "A" DAY			2a. DATE OF DEATH MONTH DAY YEAR 05/03/87		2b. HOUR M 44
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 5 3 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 0 6	7b. HOUR M 44
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 400a Oswego Ave 21215
14. FATHER'S NAME FIRST MIDDLE LAST Gregory — Witsen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kimberly Day			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Prematurity DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-3 19 87, to 5-3 19 87, that (I) (we) last saw the deceased alive on 5-3 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.					
22b. SIGNATURE Donna L. Snyder M.D.		DEGREE		22c. DATE SIGNED 5-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna L. Snyder		22e. ADDRESS Sinai Hospital Baltimore MD			
23a. BURIAL (CREMATION) REMOVAL (SPECIFY)		23b. DATE 5-26-87	23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME SINAI HOSPITAL			ADDRESS 2401 W. BELWEDGE AVE		25a. DATE REC'D. BY REGISTRAR JUN 01 1987
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13422
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIETTA A. DAY		2a. DATE OF DEATH MONTH DAY YEAR 5 11 87		2b. HOUR 2108 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9 20 18	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT GEN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE MD	13b. COUNTY BALT	13c. CITY OR TOWN BALT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 916 FREEMAN 21225
14. FATHER'S NAME FIRST MIDDLE LAST HENRY MEYERS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ANKEWITZ		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 214037881		17. INFORMANT ADDRESS DEPREE 3001 HANOVER BALT MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/28/87 19 to 5/11/87 19, that (I) (we) lost 5/11/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEPREE, DAVID		22e. ADDRESS 3001 S. HANOVER BALT. MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/15/1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, AA Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR MAY 18 1987	25b. REGISTRAR'S SIGNATURE 	

BP

154666 MAY 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

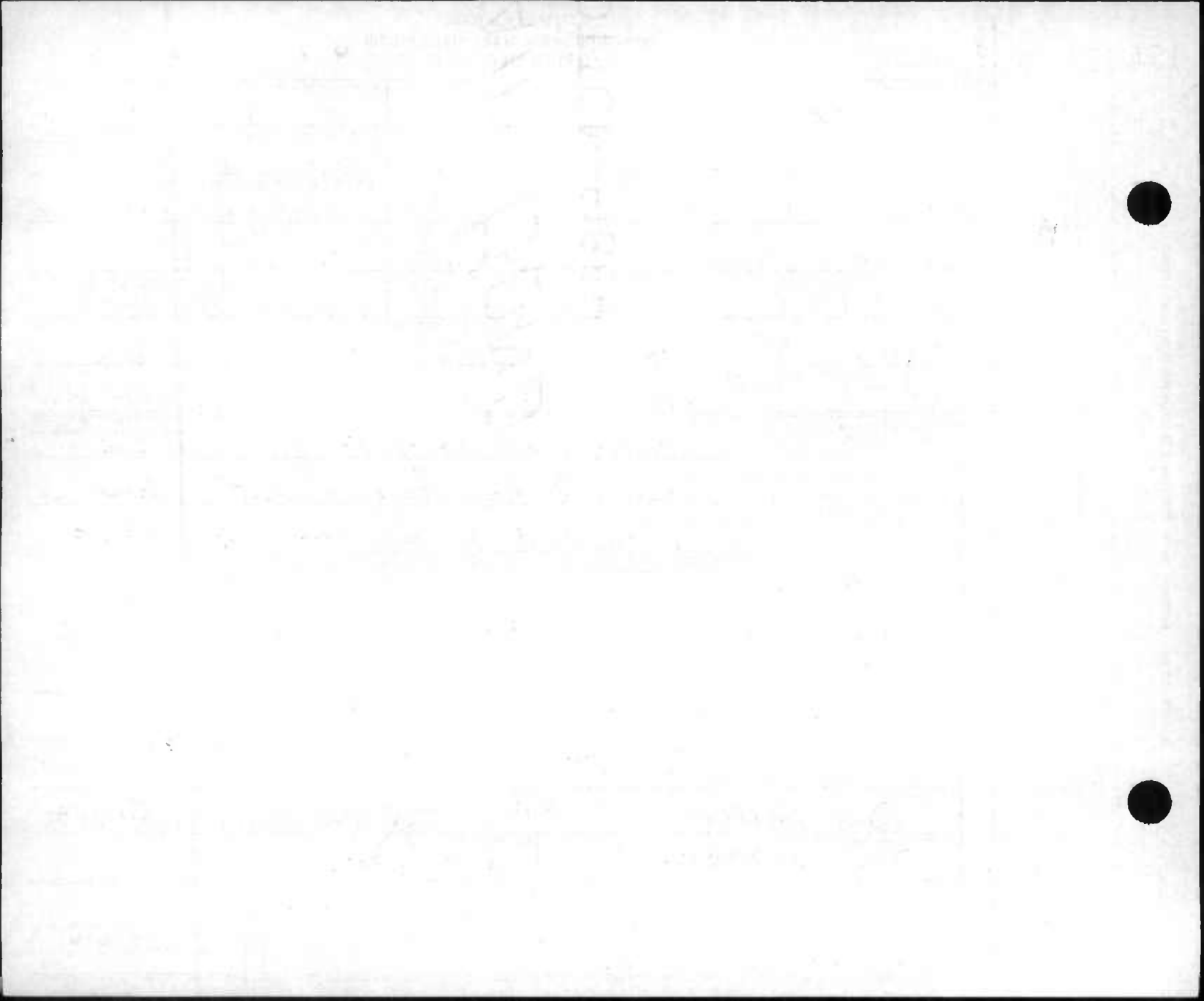
87 13423

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Dean</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5 22 87</i>		2b. HOUR <i>5:53 PM</i>
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 18 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>BA</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Linwood Dean</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susie Dean</i>		13e. STREET ADDRESS / ZIP CODE <i>7907 Subet Rd Baltimore city - 21207</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>220-05-7318</i>		17. INFORMANT ADDRESS <i>Flossie B. Dean 7907 Subet Road</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest (standstill)</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 min</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>carcinoid tumor / "carcinoid heart"</i>					<i>6 mos.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>1° carcinoid of liver (extensive)</i>					<i>18 mos.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>tubercular regurg (severe) 2° carcinoid</i>					
19a. DATE OF OPERATION <i>9/19/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>bowel obstr by carcinoid</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11/11/19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>11/11/19</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11/11/19 Baltimore City MD</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/22</i> 19 <i>87</i> , to <i>5/22</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>5/22</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dan Midongal</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/24/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAN MIDONGAL</i>		22e. ADDRESS <i>GOOD SAM.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/27/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm. C. March F/H West 4300 Wabash Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 27 1987</i>			
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Ruback</i>			

MEDICAL CERTIFICATION

BP



054954 JUN - 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 3 4 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Elizebeth Decker			2a. DATE OF DEATH MONTH DAY YEAR 5-26-87			2b. HOUR 1:10 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 30 96		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. JENKINS MEMORIAL HOME (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 S. Caton Ave. Balt; Md. 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales lady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Pembroke Price		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu Eney		16. SOCIAL SECURITY NO. 214-30-4397				
17. INFORMANT John P. Decker, 139 Northbend Road		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) HA SCVD DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 10-4 , 19 78 , to 5-26 , 19 87 , that (we) lost saw the deceased alive on 5-26 , 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.								
22b. SIGNATURE John F. Hartman, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-26-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. HARTMAN				22e. ADDRESS JENKINS-1000 S. CATON AVE. 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP.

before discussion

1000 A. Mason Ave. Salt Lake City, Utah
Jennie Memorial Home

2025 COLLECTION

054754 MAY 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 3 4 2 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST JENNIE		MIDDLE DEMBO		LAST DEMBO		2a. DATE OF DEATH MAY 22, 1987		MONTH DAY YEAR		2b. HOUR 11 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 9, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6320 GREENSPRING AVE., APT. 408		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6320 GREENSPRING AVE. #21209					
14. FATHER'S NAME FIRST LOUIS		MIDDLE		LAST WILDSTEIN		15. MOTHER'S MAIDEN NAME FIRST REBECCA		MIDDLE		LAST BURELSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-52-3781		17. INFORMANT DONALD DEMBO		ADDRESS APT. B-1 722 CAMBERLY CIR. TOWSON, MD 21204							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Progressive disease.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>unknown</u> 19 <u>86</u> to <u>5/22</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>unknown</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.													
22b. SIGNATURE <u>P. Kennedy M.D.</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNEDY				22e. ADDRESS UMCC.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 24, 1987		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION BALTIMORE		COUNTY		MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Rodgers</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2837.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN D DEMETER			2a. DATE OF DEATH MONTH DAY YEAR MAY 24, 1987		2b. HOUR 4:25 AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 3 19 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIRECTOR/SPEECH	12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13a. STATE VIRGINIA	13b. COUNTY FAIRFAX	13c. CITY OR TOWN ALEXANDRIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9221 VOLUNTEER DRIVE (22309)	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J DEMETER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILDA H FRYE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1950-1954		17. INFORMANT ADDRESS Chesapeake, VA 23320	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pancreatic Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 months</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes
19a. DATE OF OPERATION 4/27/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pancreatic Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>APR 26</u> , 19 <u>87</u> , to <u>May 24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>L. H. Riley, III, MD</u>		DEGREE MD		22c. DATE SIGNED May 24, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lee H. Riley, III, MD		22e. ADDRESS 600 N. WOLFE ST BALTO 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-27-87	23c. NAME OF CEMETERY OR CREMATORY MONONGAHELA CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE MONONGAHELA, PENNSYLVANIA	
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA		25a. DATE REC'D. BY REGISTRAR JUN 04 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

025304



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

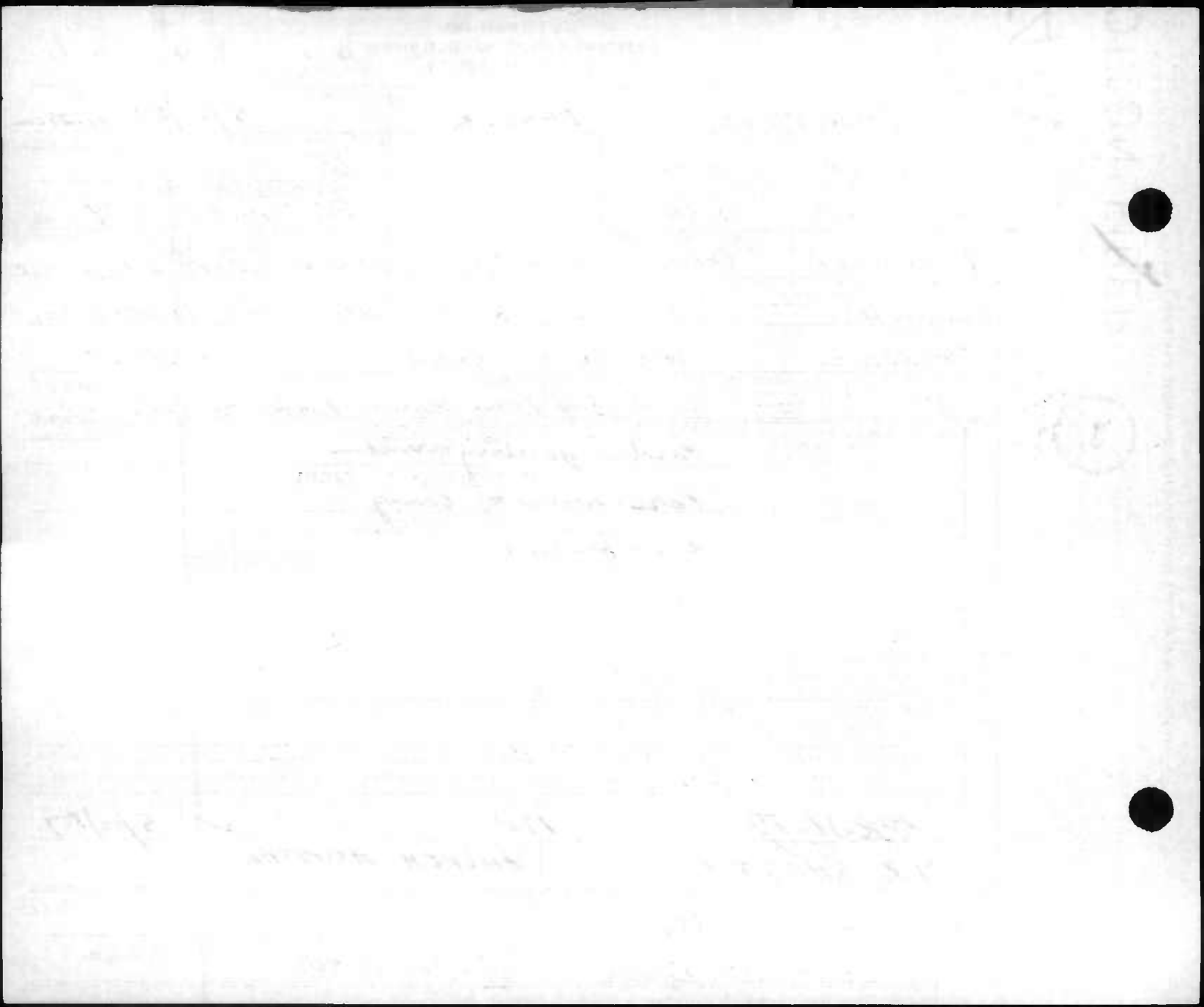
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic element, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 13427	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVIEVE DENSUK					2a. DATE OF DEATH MONTH DAY YEAR 5/10/87			2b. HOUR 4-28am			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV 15 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WESTERN ELECTRIC WIRE SPICER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 447 DURHAM BALTO. 21231			
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE DENZUK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BOYKO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-01-5146		17. INFORMANT FRANK DENSUK		ADDRESS 9214 Gardenia RD. BALTO. 21236					
18. CAUSE OF DEATH (Enter only one cause per part. If more than one, list in Part 2.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>CARCINOMA OF LUNG</u> (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF <u>LIVER FAILURE</u> (c) <u>Liver failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NA											
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 05/87</u> 19 <u>87</u> to <u>05/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Y.K. Shetty</u>						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/10/87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y.K. SHETTY						22e. ADDRESS CHURCH HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/13/87		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Lilly & Zeller						ADDRESS BALTO 1901 EASTERN AVE 21231		25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE <u>Robert H. Hender</u>	

BP



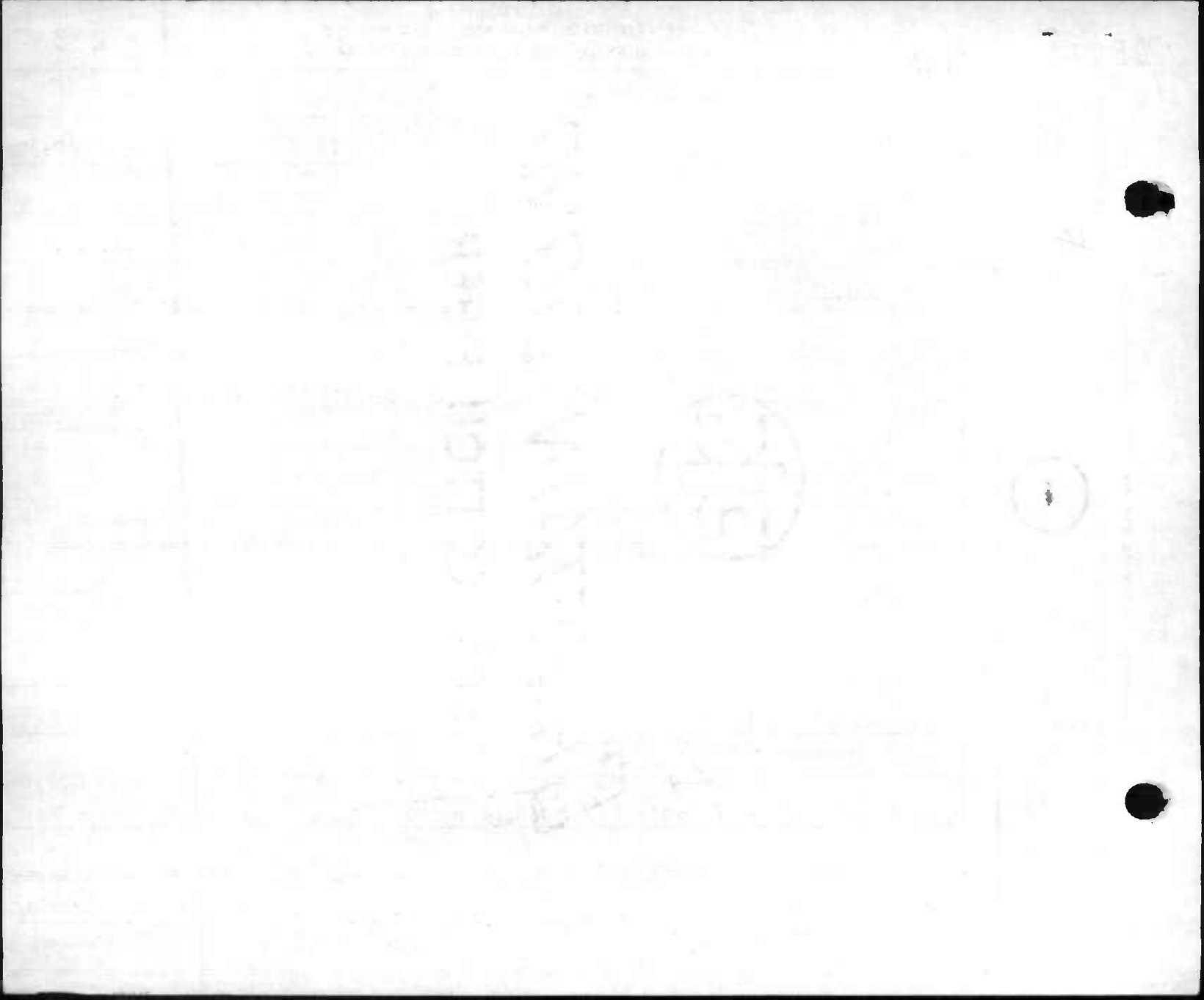
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13428

FOR 1- STATE REGISTER		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF ESTI-MATED		2d. HOUR	
EARL Norris DEREMER		5-16-87 19		M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	Caucasian	July 20, 1912	74 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	United States	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	University Hospital	Bus Driver	P.A.T.A.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Pennsylvania	Allegheny	Wilkins Twnshp	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	99999 910 Stevendale Dr./15221	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Charles Deremer	Elizabeth Martin	170 01 4817			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
Yes	WW II	Agnes Deremer(Wife) Same as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Blunt trauma to head					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
arteriosclerotic cardiovascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
PM P.M. 5-4-87 19		subject fell striking head			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
bathroom		Inner Harbor		Baltimore, Maryland	
22a. I certify that I took charge of the remains described above (HEAD ONLY) <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant		5-17-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dennis F. Smyth, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	May, 20, 1987	Wm. Penn Memorial Cem.	Wilkins Township Pennsylvania		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		MAY 19 1987		Julia Davidson-Randall	
7557 Wisconsin Avenue, Bethesda, Maryland					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BRACKETED ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

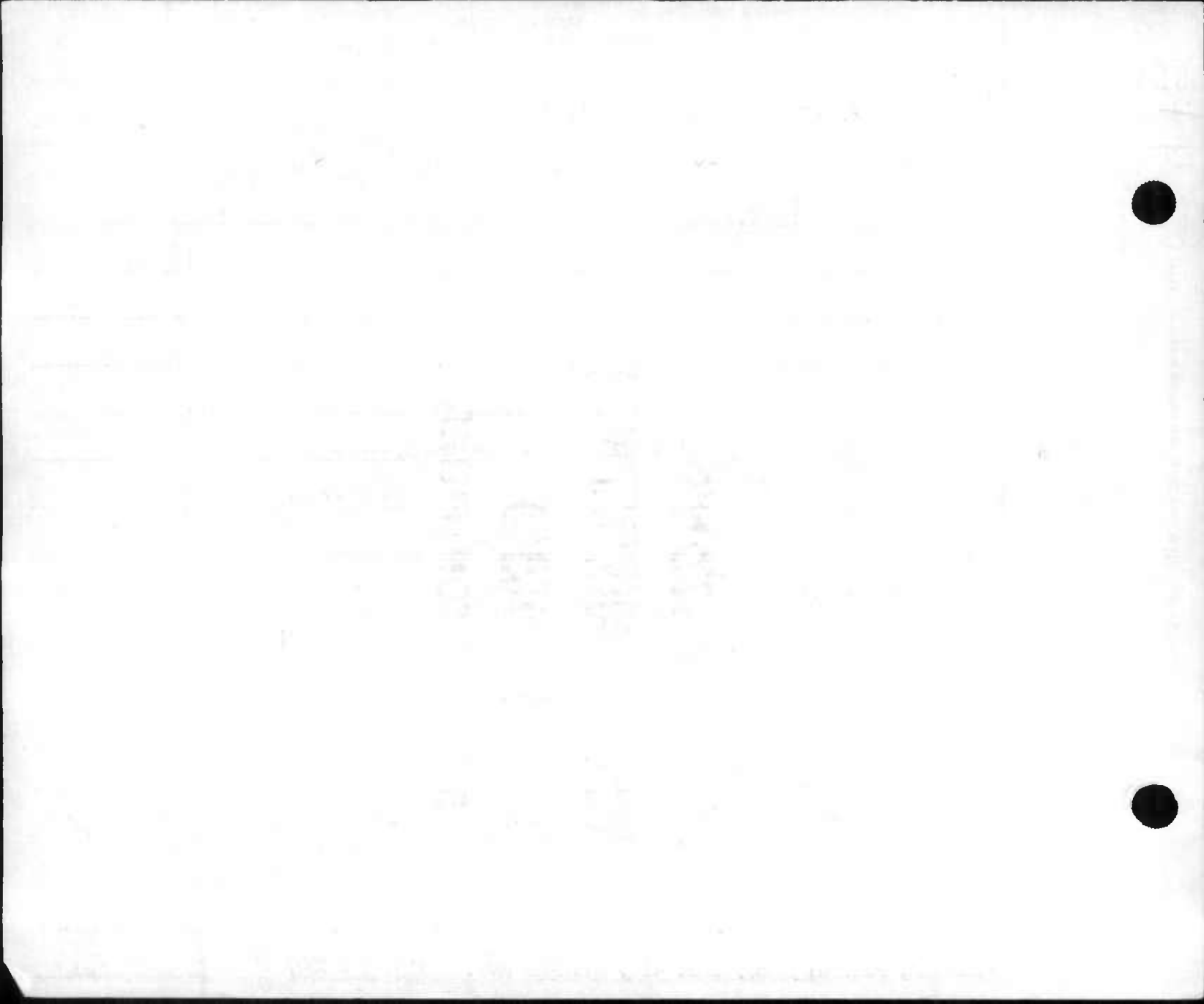
8 7 1 3 4 2 9

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH N. DETTMER			2a. DATE OF DEATH MONTH DAY YEAR 5-24-87		2b. HOUR 3:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 16 30		
6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7a. CITIZEN OF WHAT COUNTRY? U.S.A.		7b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
12b. KIND OF BUSINESS OR INDUSTRY ---		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2115 CHRISTIAN STREET 21223		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY ANDREW WISSMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN N. CORBIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 218-26-5300		17. INFORMANT Dianna R. Pyle		2123 Ramsay St. 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) /						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: INV. DEP. DIABETES MELLITUS; CHRONIC OBSTRUCTIVE PULM DIS.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 5/24/1987 to 5/24/1987, that (I) (we) last saw the deceased alive on 5/24/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Anish Kumar Chopra		
22c. DATE SIGNED 5/24/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.K. CHOPRA		22e. ADDRESS 3455 WILKENS AVE BALTO. MD 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland		24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		
25b. REGISTRAR'S SIGNATURE Julia T. [Signature]		25c. ADDRESS 21229		25d. REGISTRAR'S SIGNATURE		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic evidence, the medical examiner must be notified promptly.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 0

REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST PATRICK	MIDDLE Francis	LAST DEVLIN	2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1987		2b. HOUR 5:52P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 1 47		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY Police		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Pa.		13c. COUNTY Phila.		13d. CITY OR TOWN Phila		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 6375 Columbia Ave. 19151		
14. FATHER'S NAME FIRST MIDDLE LAST Francis J. Develin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McAleer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1966-68		17. INFORMANT Joanne Devlin		ADDRESS 6375 Columbia Ave. Phila. Pa. 19151				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic Myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Sepsis, cholestatic hepatitis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>87</u> , to <u>5-1</u> , 19 <u>87</u> , that (1) (we) saw the deceased alive on <u>5-1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Walter N. Kernan</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/1/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter N. Kernan				22e. ADDRESS 600 N WOLFE ST 21205 % Johns Hopkins Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/87		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Conshocken, Pa.				
24. FUNERAL DIRECTOR Capitol Funeral Service 7213 Lee Highway Falls Church, Va. 22046				25a. DATE REC'D. BY REGISTRAR MAY 4 1987		25b. REGISTRAR'S SIGNATURE Julia Decker-Rudner				

153-712-1
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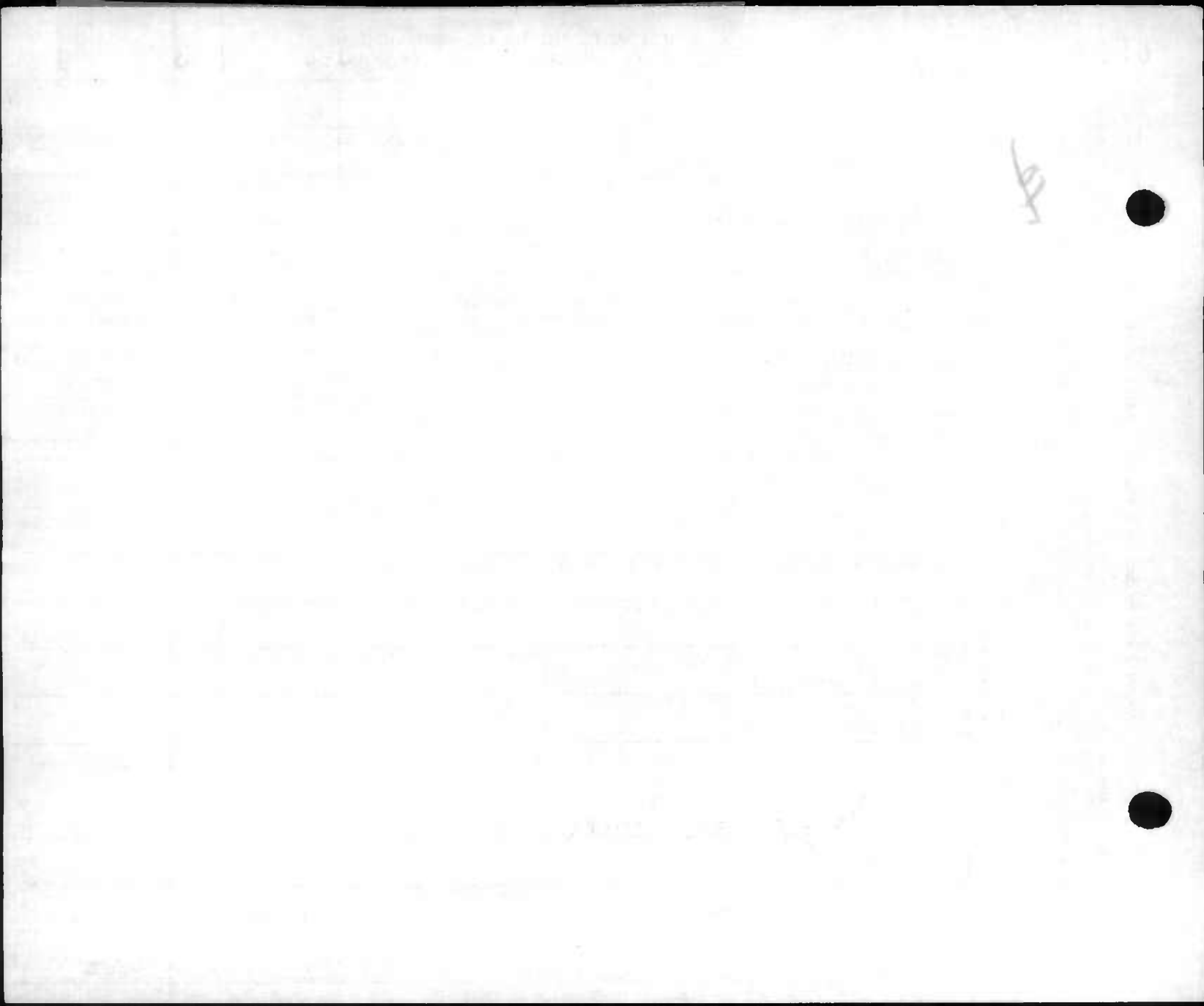
053362

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13431	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ann Marie DiBerardo										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 8 19 87	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-18-1931		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 8 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4244 Shamrock Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Accounting			
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4244 Shamrock Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Henry J. Hammel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ann Schrufer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 218-28-3324		17. INFORMANT ADDRESS Louis J. DiBerardo (husband) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissection of thoracic aorta with hemopericardium</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margarete A. Korell</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 5/9/87			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St. Balto.MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/12/87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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54672 MAY 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

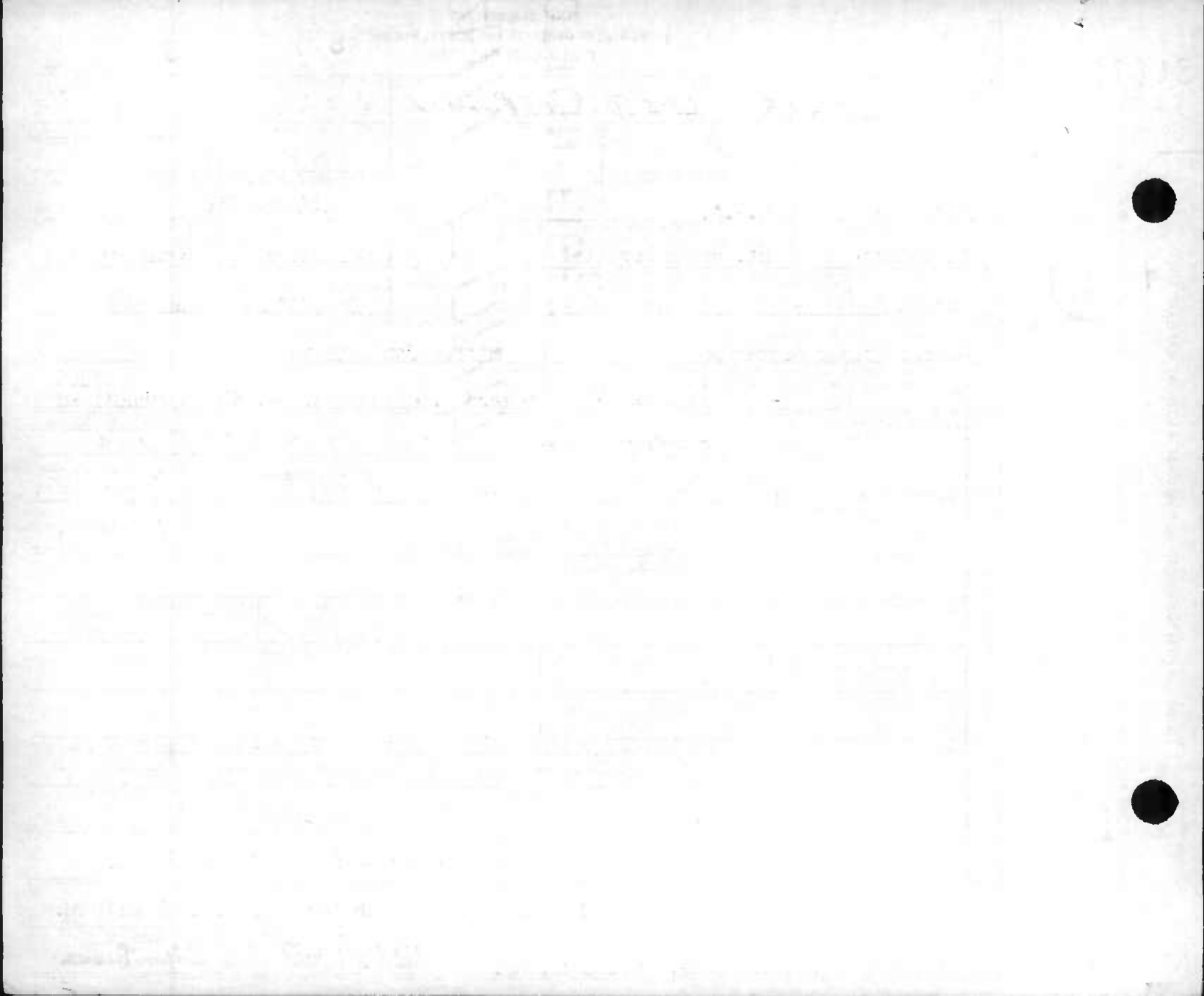
REG. NO.

87

13432

1. DECEASED NAME (TYPE OR PRINT) EDGAR Lee DICKERSON			2a. DATE OF DEATH MONTH DAY YEAR 5/22/87			2b. HOUR 7.50 P.M.				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 30 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland					13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Arthur Dickerson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Millie Jan Keith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 212 18 2717		17. INFORMANT ADDRESS Edward L. Dickerson, Jr. 5508 Bucknell Rd 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). CARDIO PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LONG STAY RESPIROTORARY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC LUNG CANCER (c) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 1 WEEK										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 87 , to 5/22 , 19 87 , that (I) (we) last saw the deceased alive on 5/22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. Maciulis						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MACIULIS						22e. ADDRESS ST. AGNES HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 05 26 87		23c. NAME OF CEMETERY OR CREMATORY Bosley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Thorton Mill Rd. Baltimore Co Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home, Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR MAY 27 1987				
						25b. REGISTRAR'S SIGNATURE John S. Anderson				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROBERT A DICKSON		5 18 87		7 10 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
M ALE	W HITE	5/ 19 78	69	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
SOUTH DAKOTA	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	ST AGNES HOSPITAL	RET. COLONEL	U.S. AIR FORCE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD	HOWARD	HIGHLAND	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13981 FT 108 20777	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
CYRUS J. DICKSON	MARY UPTON	YES WW II-KOREAN 503-46-3565			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
	NONA DICKSON	SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiogenic shock					5 wks
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction					5 wks
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from 5/18/87, 19 87, to 5/18 19 87, that (I) (we) last saw the deceased alive on 5/18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED		
Paul Grimes, MD			5/18/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
Paul Grimes, MD	St. Agnes Hosp., BALTIMORE, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY STATE	
BURIAL	5/26/87	ARLINGTON NATIONAL	ARLINGTON	VIRGINIA	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LEROY T. & RUSSELL C. WITZKE FUNERAL HOMES P.A.		MAY 21 1987		[Signature]	
5555 TWIN KNOLLS ROAD, COLUMBIA, MARYLAND 21045					

BP

Handwritten text at the bottom left corner, possibly a signature or date, appearing to read "1901 15 10" or similar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 4

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theodis Diggs			2a. DATE OF DEATH MONTH DAY YEAR May 25, 1987		2b. HOUR 4:45 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 4 33	6. AGE (IN YEARS (LAST BIRTHDAY)) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1816 Rutland Ave. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Diggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Romalee Diggs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 245-46-1317		17. INFORMANT ADDRESS Romalee Robinson 1816 Rutland Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Unknown Primary with Lung Invasion</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Deep Vein Thrombosis, Pleural Effusion</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <u>May 20 -</u> , 19 <u>87</u> , to <u>May 25,</u> 19 <u>87</u> , that (X) (we) lost saw the deceased alive on <u>May 25,</u> 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE <u>D. Bernal</u>		DEGREE		22c. DATE SIGNED <u>5/25/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DELFIN BERNAL</u>		22e. ADDRESS <u>c/o Maryland General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/31/87	23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Wadesboro N.C.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 26 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Rodriguez</u>	

OLD OMNIS 1111

1111-1111 1111-1111
1111-1111 1111-1111



Handwritten signature or initials
1111-1111 1111-1111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis C. DiMarino			20. DATE OF DEATH MONTH DAY YEAR May 1, 1987		2b. HOUR M M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-13-1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3515 Royston Avenue-21206	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3515 Royston Avenue-21206		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Work	
12c. KIND OF BUSINESS OR INDUSTRY Martin Marietta		14. FATHER'S NAME FIRST MIDDLE LAST Nicholas DiMarino		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Repitto	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 216-03-6519		17. INFORMANT ADDRESS Jeanette E. DiMarino - 3515 Royston Ave.-21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Massive Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus; anemia; Anemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-1 19 80 , to 5-1 19 87 , that (I) (we) last saw the deceased alive on 5-1 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jaime Punzalan		DEGREE		22c. DATE SIGNED 5/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAIME PUNZALAN		22e. ADDRESS 5214 Haydon W. Balto. Md. 21214			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller, Inc.-6415 Belair Road-21206		25a. DATE REC'D. BY REGISTRAR MAY 4 - 1987	

George Washington

My dear Sir
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above mentioned subject. I am sorry to hear that you are not satisfied with the result of the examination. I have been very anxious to see that the work was done to the satisfaction of all parties concerned. I have been very busy lately, and have not had time to devote to this matter as much as I would wish. I have, however, been very careful to see that the work was done to the best of my ability. I have been very anxious to see that the work was done to the satisfaction of all parties concerned. I have been very busy lately, and have not had time to devote to this matter as much as I would wish. I have, however, been very careful to see that the work was done to the best of my ability.

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Yours truly,
J. B. Smith

053584 MAY 5

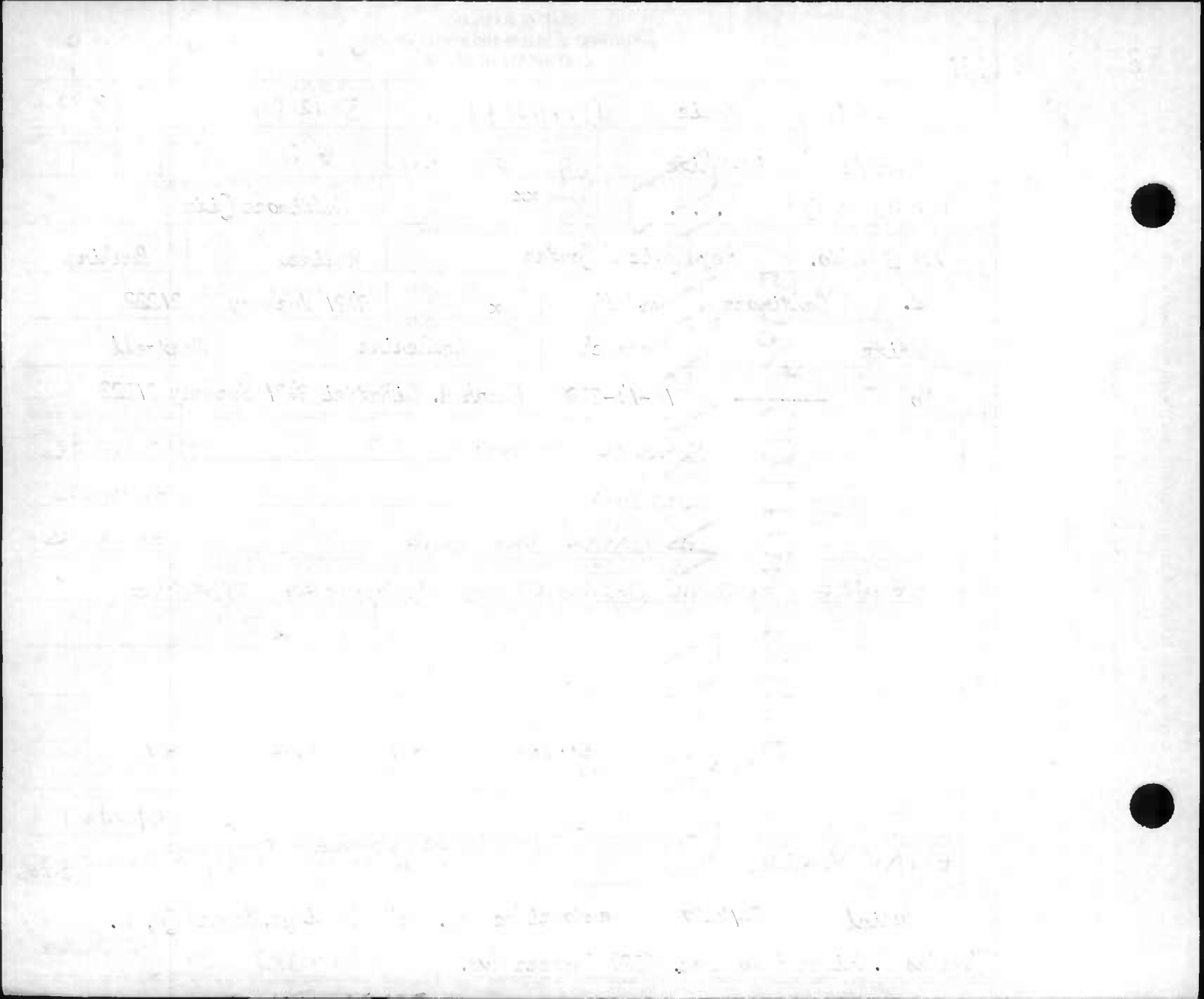
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 answers any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 1 3 4 3 6	
1. DECEASED NAME (TYPE OR PRINT) Sally Marie DiMattei						2a. DATE OF DEATH MONTH DAY YEAR 5-12-87		2b. HOUR 3:45 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 29 24		6. AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH MD Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. STATE MD.						13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 3421 Yorkway 21222					
14. FATHER'S NAME FIRST MIDDLE LAST Moritz Benesch						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Mertzell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-2230		17. INFORMANT ADDRESS Frank A. DiMattei 3421 Yorkway 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPOXIA DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA										36 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA										36 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/11/87 , 19 87 , to 5/12 , 19 87 , that (I) (we) last saw the deceased alive on 5/12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Elia Barr MD								DEGREE		22c. DATE SIGNED 5/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELIA BARR								22e. ADDRESS DR'S LOUNGE - TOWER 100 JOHNS HOPKINS HOSP, BALTIMORE, MD 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard Co, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Charles S. Zeiler & Son Inc. 6224 Eastern Ave.						25a. DATE REC'D. BY REGISTRAR MAY 14 1987		25b. REGISTRAR'S SIGNATURE Wendell			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Floyd		MIDDLE Dlugoboski		LAST Dlugoboski		2a. DATE OF DEATH MONTH DAY YEAR 5/1/87		2b. HOUR 10⁴⁵ PM	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1-10-1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key M.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Mill - Retiree		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3522 Mt. Pleasant Ave 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Dlugoboski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Redyk				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 213-05-5953		17. INFORMANT ADDRESS Mrs. Georgianne Snowden 3522 Mt. Pleasant Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF, (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) sleep apnea								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/26 , 19 87 , to 5/1 , 19 87 , that (I) (we) last saw the deceased alive on 5/1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Williams MD						DEGREE		22c. DATE SIGNED 5/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy Williams MD				22e. ADDRESS FSK Medical Center Balto, MD 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-5-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr.		ADDRESS 263 S Conkling St. 21224		25a. DATE REC'D. BY REGISTRAR MAY 4 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified **immediately**.

BP_____



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 8

REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Nick	MIDDLE J.	LAST Dontas	2a. DATE OF DEATH MONTH DAY YEAR 5-10-87		2b. HOUR 6 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-17-1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6310 Fairdel Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6310 Fairdel Ave. 21206		
14. FATHER'S NAME FIRST MIDDLE LAST John Dontas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celly Sitaras						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 089-16-7299		17. INFORMANT ADDRESS Mary Dontas, Same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cadise arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 1972								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 26 May 1987		21g. I certify that (I) (this hospital) attended the deceased from May 17 1987 to May 19 1987 , that (I) (we) last saw the deceased alive on May 17 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
22a. SIGNATURE Charles M. Kerr MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-11-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Kerr MD				22e. ADDRESS 6801 Belvoir Rd 21206						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-12-87		23c. NAME OF CEMETERY OR CREMATORY St. Demetrios		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Julia T. Ruck				

BP

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John	Contingent	Colly	2-10-87
Ad.	Contingent	Colly	2-10-87
John	Contingent	Colly	2-10-87
Ad.	Contingent	Colly	2-10-87
John	Contingent	Colly	2-10-87
Ad.	Contingent	Colly	2-10-87
John	Contingent	Colly	2-10-87
Ad.	Contingent	Colly	2-10-87
John	Contingent	Colly	2-10-87
Ad.	Contingent	Colly	2-10-87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 3 9
REG. NO.

FOR STATE REGISTRAR						CERTIFICATE OF DEATH						REG. NO. 8713439					
1. DECEASED NAME (TYPE OR PRINT) Elvira E Dorsey						2a. DATE OF DEATH MONTH DAY YEAR 5 12 87						2b. HOUR 9³⁶ P.M.					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 09 19 03		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD											
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2310 Dorsey Avenue 21215							
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Dorsey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Kelly													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-307050		17. INFORMANT ADDRESS William Jones (SON) 3713 W. Cold Spring Baltimore, Md. 21215											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST																	
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) LFT Hemispheric cerebrovascular accident																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that (I) (this hospital) attended the deceased from May 87 , to May 12 , 19 87 , that (I) (we) lost saw the deceased alive on May 12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Robert Roby						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Roby						22e. ADDRESS Sinai Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-19-87		23c. NAME OF CEMETERY OR CREMATORY Locust Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Simpsonville, Howard, MD							
24. FUNERAL DIRECTOR NAME George R. Snowden						ADDRESS 246 N. Washington Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Arlene Anderson-Peddy							

50-11-10



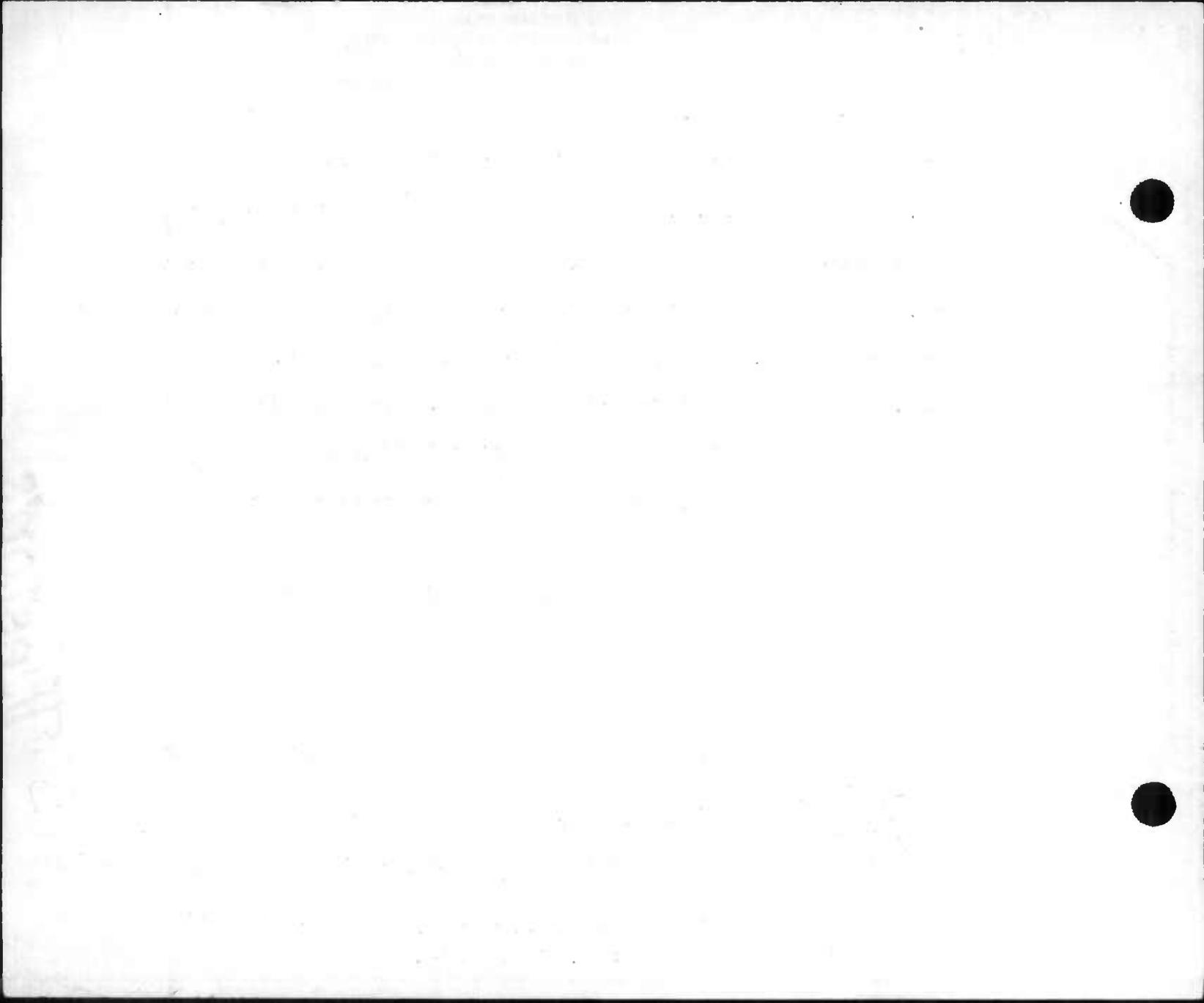
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 7 1 3 4 4 0	
CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jerna R. Dorsey				2a. DATE OF DEATH MONTH DAY YEAR 5 23 87		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 19 32		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Seaman.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 506 McCabe Ave. 21212		
14. FATHER'S NAME FIRST MIDDLE LAST Norman R. Dorsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion E. Dutton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-7448		17. INFORMANT ADDRESS Vera D. Jacques 506 McCabe Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arterio-sclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASTHMATIC BRONCHITIS NEW ONSET Diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/22/87, 19 85, to 5/23, 19 87, that (I) (we) last saw the deceased alive on 5/22/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (we) did not view the body after death.)						
22b. SIGNATURE Patricia Jenkins MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA Jenkins MD				22e. ADDRESS 2300 Garrison Boulevard suite 150 Baltimore 21216		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md.
24. FUNERAL DIRECTOR MARCH FUNERAL HOME 1101 E. North ave.				25a. DATE REC'D. BY REGISTRAR MAY 28 1987		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		



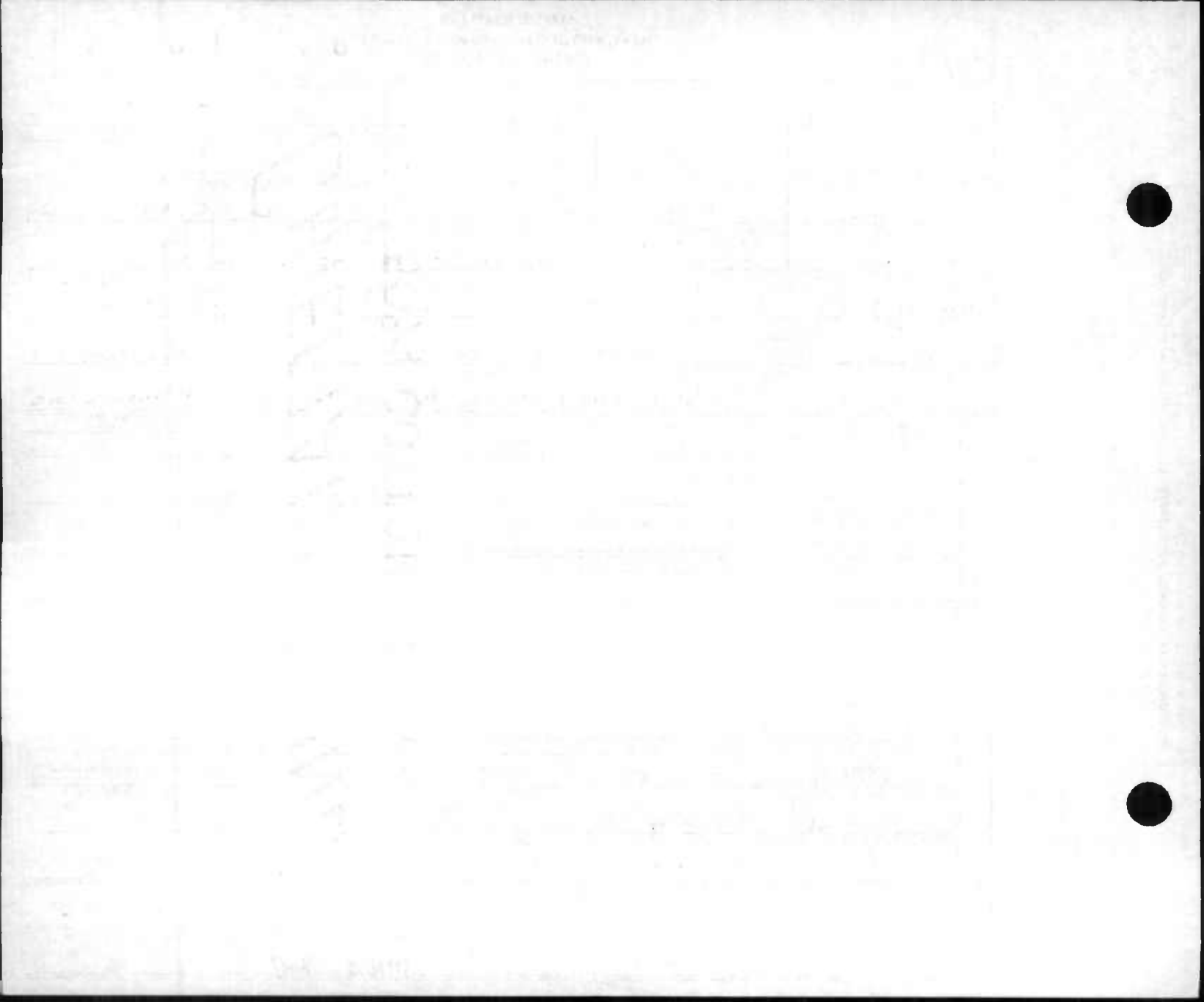
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

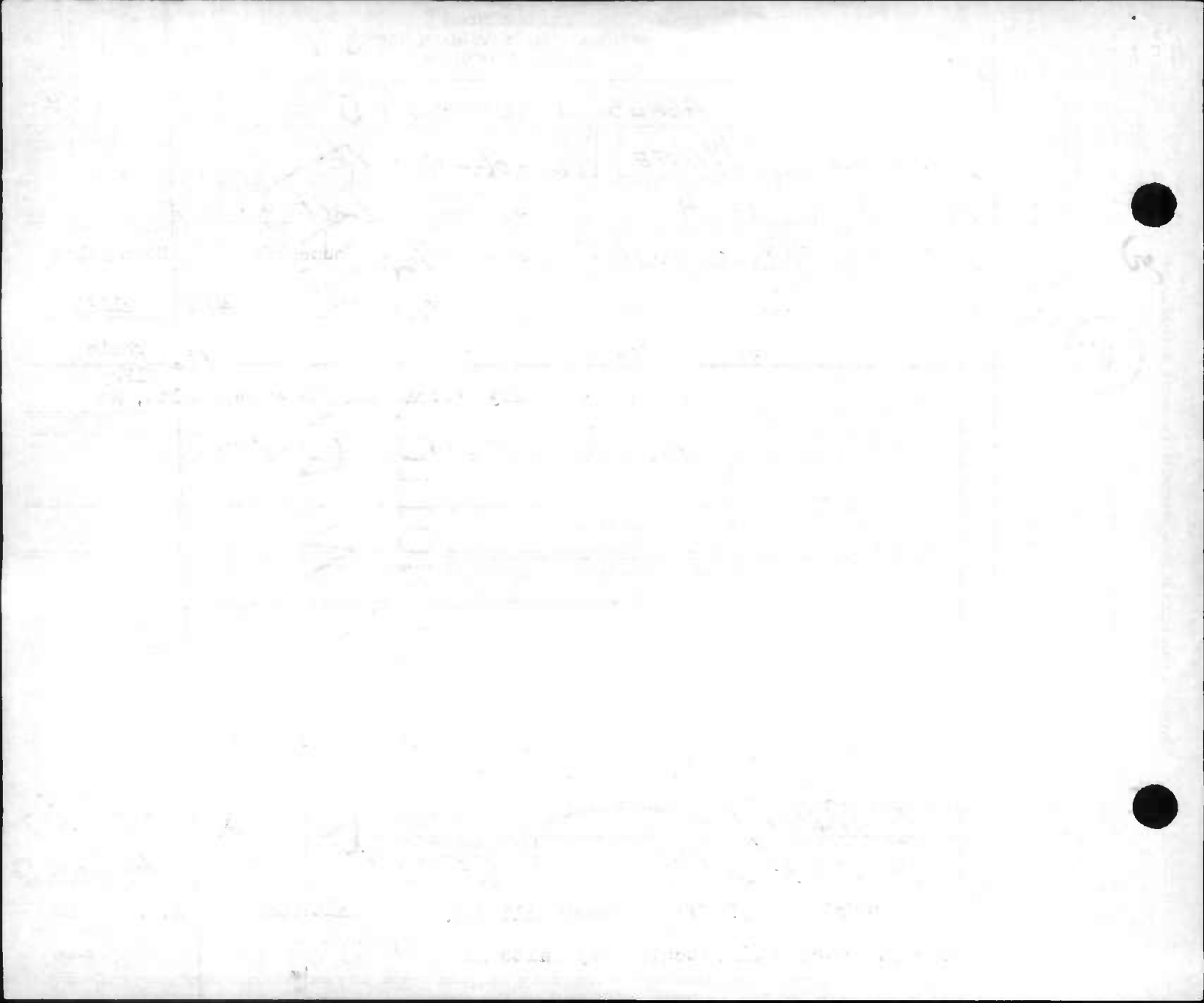
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 13441	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE DOUGLAS				2a. DATE OF DEATH MONTH DAY YEAR 5 30 87	
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 31 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Scott Baltimore General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		21061	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN GLEN SUENE	
14. FATHER'S NAME FIRST MIDDLE LAST George Scott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Dorsen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-7109		17. INFORMANT ADDRESS Horace Douglas 125 warwickshire lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE Atherosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/30/87, 19, to 5/30, 1987, that (I) (we) last saw the deceased alive on N/A 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel Wenberg		DEGREE MD		22c. DATE SIGNED 5/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL WENBERG		22e. ADDRESS 3001 S. Hanover Baltimore MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		23d. LOCATION OWINGS MI 9th's MD		25a. DATE REC'D. BY REGISTRAR JUN 4 1987	
25b. REGISTRAR'S SIGNATURE T. J. Anderson					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE AGNES LAST DOWLING		2a. DATE OF DEATH MONTH DAY YEAR 5-20-87		2b. HOUR 11:44 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06-06-1900		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Baltimore, MD		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker		13a. STREET ADDRESS / ZIP CODE 107 N 6th Ave 21225	
14. FATHER'S NAME Edward Franklin Douglass		15. MOTHER'S MAIDEN NAME Barbara Amrhein		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 214741123		17. INFORMANT Mary Hoffman		17b. ADDRESS 21225 5th Avenue Balto, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from 5-17-87 to 5-20-87 that (we) lost saw the deceased alive on 5-20-87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.			
22b. SIGNATURE AMAETHULE		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 5/20/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS 886 H, 3001 S. Hanover St			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/23/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
23d. LOCATION BALTIMORE		23e. COUNTY A.A.		23f. MD	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



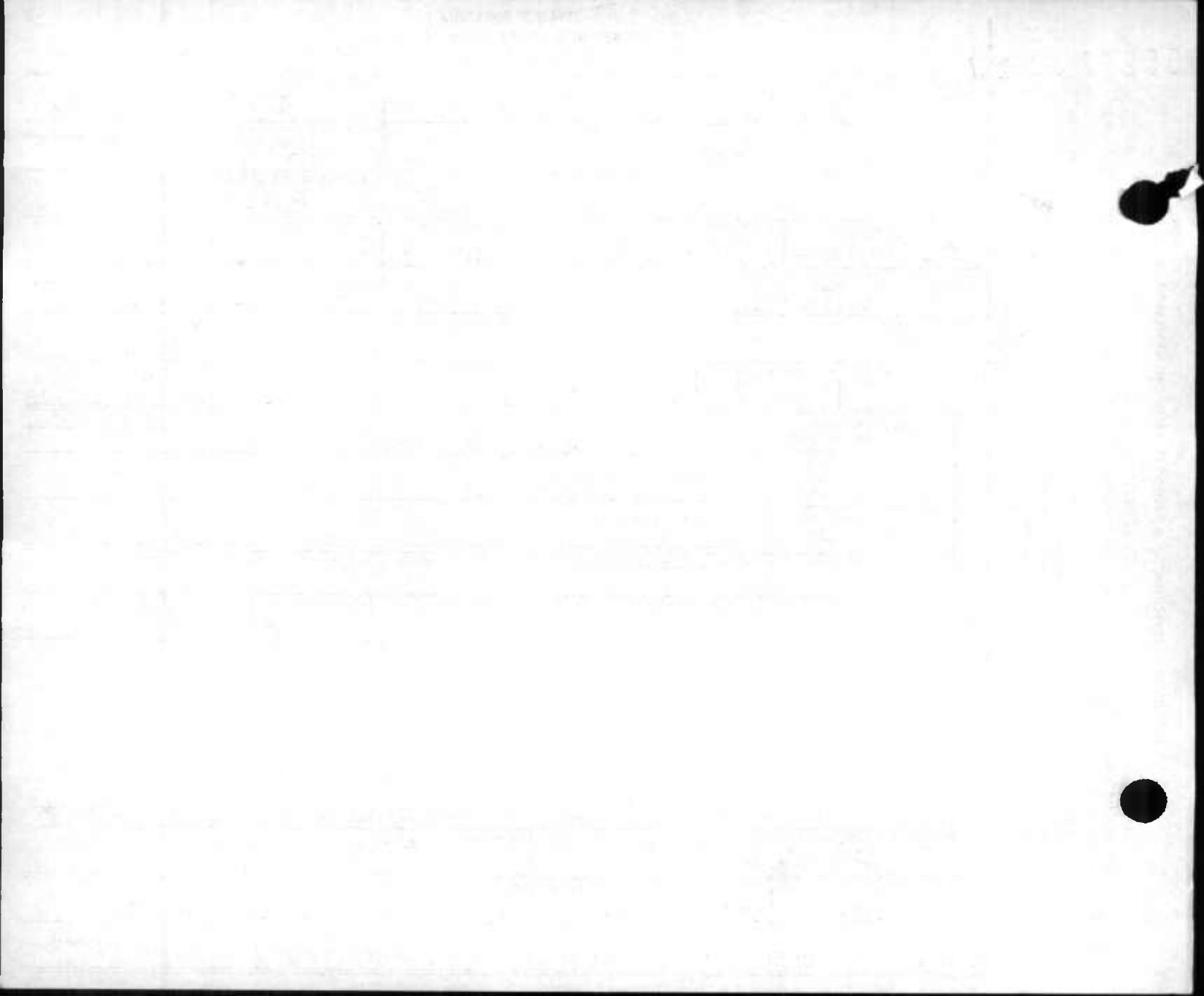
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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha c. DOWNS		2a. DATE OF DEATH MONTH DAY YEAR 05 129/87		2b. HOUR 859 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 24, 1904	
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Cntr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Emil Koepf		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Lindner		17. INFORMANT ADDRESS Robert L. Myers, Jr. Baltimore, MD 21234	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-7017		17. INFORMANT ADDRESS Robert L. Myers, Jr. Baltimore, MD 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) colon ca Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 05/28/87 to 05/29/87, that (I) (we) lost saw the deceased alive on 05/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janczur M.D.		DEGREE		22c. DATE SIGNED 5/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANCZUR M.D.		22e. ADDRESS FSK HOSP		22f. DATE SIGNED 5/29/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 1, '87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		23e. DATE REC'D BY REGISTRAR JUN 1 1987		23f. REGISTRAR'S SIGNATURE Julia Gordon-Randall	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		ADDRESS 8521 LOCH RAVEN BLVD		25a. DATE REC'D BY REGISTRAR JUN 1 1987	

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 13444

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Anna M. Doyle		5 7 87		12 noon	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	94	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Ireland	Ireland		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	1541 Shadyside Rd. 21218		Housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Maryland			Baltimore	1541 Shadyside Rd. 21218	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Thomas Madden		Margaret Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217-18-3858 A		Mr. Thomas Doyle 1541 Shadyside Rd. 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>					<u>2 weeks</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u>					<u>years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Peripartum preeclampsia</u>					<u>years</u>
(d) <u>ASCVD</u>					<u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 23rd 87</u> to <u>March 19th 87</u> , that (I) (we) last saw the deceased alive on <u>March 19th 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>		M.D.		5-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CARLOS E. ARANAGA, M.D.		1900 E. Northern Parkway Balto 21239			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		5/11/87	Dulaney Valley Cemt.		Timonium Balto. Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld		6500 York Rd.		MAY 14 1987	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked B, item 18 should be any injury, or other traumatic event, this medical information should be filled in.

BP

 DHMH - 16 60M 7/84
 (VRA 15, 4)

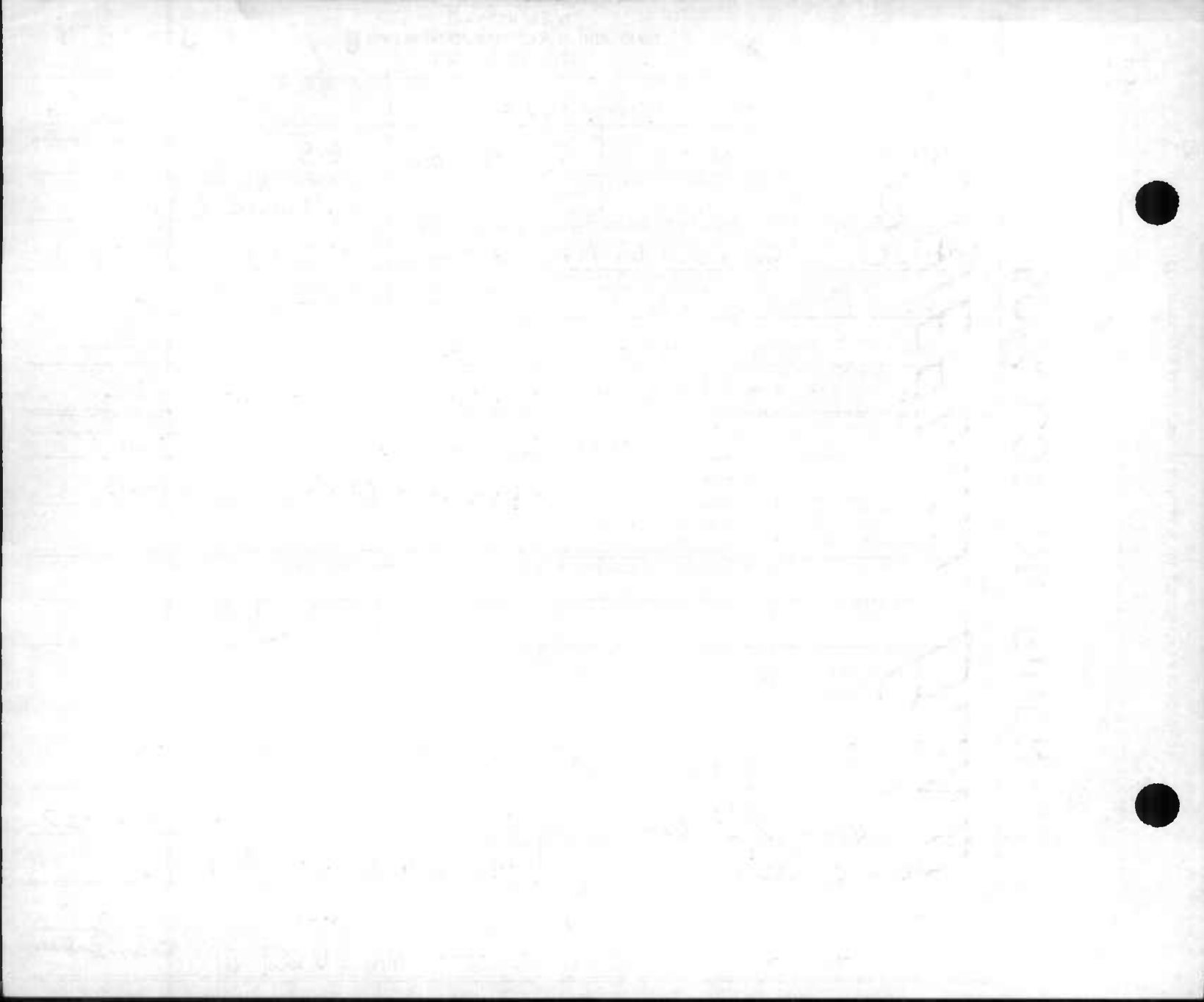
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 7 1 3 4 4 5

 1- FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Charles Vincent Doyle			2a. DATE OF DEATH MONTH DAY YEAR 05 20 87		2b. HOUR 3:45 a.m.	
3. SEX M Male	4. RACE W White	5. DATE OF BIRTH MONTH DAY YEAR 03 11 02		6. AGE (IN YEARS LAST BIRTHDAY) 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tank Tester		
12b. KIND OF BUSINESS OR INDUSTRY Ship Building		13a. STREET ADDRESS / ZIP CODE 13 Liberty Pkwy./21222				
13b. STATE Maryland		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Joseph Doyle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McNamara				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1923-1928		17. INFORMANT ADDRESS Balto., Md.		
		17. INFORMANT V. Robert Doyle		17. INFORMANT ADDRESS 117 Dunkirk Rd./ 21212		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF (b) Complete Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) hours						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:20 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (if in this hospital) attended the deceased from 5/20 , 19 87 , to 5/20 , 19 87 , that (we) last saw the deceased alive on 5/20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (and) I did not view the body after death.						
22b. SIGNATURE Richard Goldman		DEGREE MD		22c. DATE SIGNED 5/20/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Goldman		22e. ADDRESS 4940 Eastern Ave Balt. MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/1987		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d. LOCATION CITY OR TOWN COUNTY STATE Rosedale Balto., Md.						
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.		ADDRESS Balto., Md. 21222		25a. DATE REC'D. BY REGISTRAR MAY 26 1987		
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall		



055640 JUN 5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13446

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Herman L. Drewery								<input checked="" type="checkbox"/>		5-27		19		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	4 5 21		66 YRS		MONTHS		DAYS		5-27-		19		87		7:54A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
N.Y.		USA		<input type="checkbox"/> WIDOWED		<input checked="" type="checkbox"/> NEVER MARRIED		Baltimore City								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		1125 Argyle Avenue		N/A													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				Baltimore		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		1125 Argyle Ave. 21201									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Herman				Drewery													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		215-12-5625		Mary Lewis		1125 Argyle Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Brain Tumor															
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
						<input checked="" type="checkbox"/>		<input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Margarita A. Korell		Assistant		5-17-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Margarita A. Korell, M.D.		111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		6/4/87		Garrison Forest VA		Owings Mills				MD							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wm. C. March F/H		1101 E. North Ave.		JUN 3 1987													

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053973 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please return it to the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP _____

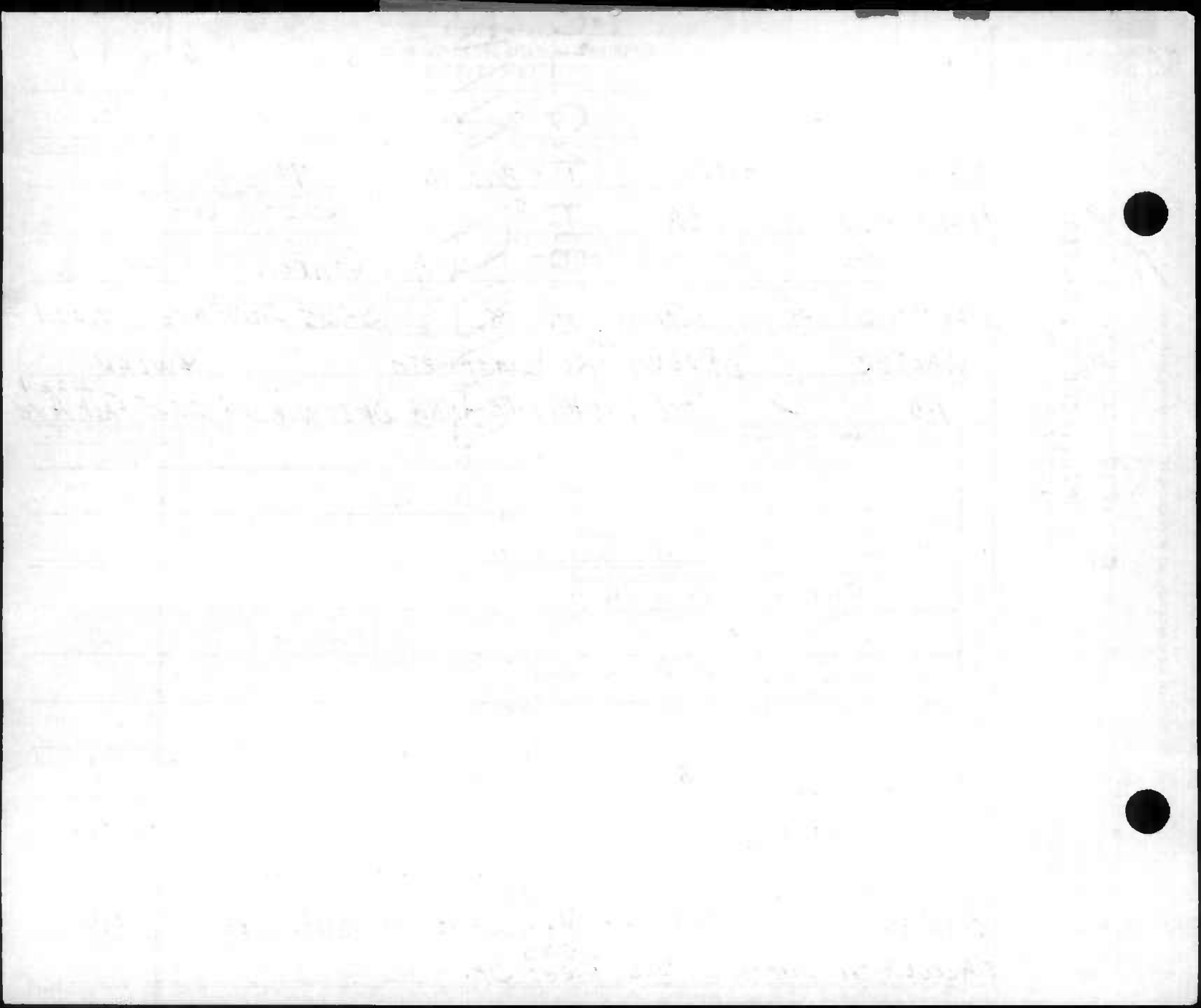
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER DRZEWIECKI JR			2a. DATE OF DEATH MONTH DAY YEAR MAY 16, 1987		2b. HOUR 10:00A ^M
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 1 30 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE THE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WALTER DRZEWIECKI JR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH RAWLAK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-6409		17. INFORMANT ADDRESS MRS ANNA DRZEWIECKI 2525 FAIR AVE 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy Ischemic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 5 Days 5 Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Clot in Left Ventricle</u>					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>May 11</u> , 19 <u>87</u> , to <u>May 15</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>May 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark Kozek MD				22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JHH 600 N WOLFE SS 21205				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5.19.87		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem Baltimore	
23d. FUNERAL DIRECTOR NAME RACZOROWSKI FUNERAL HOME		23e. ADDRESS 2525 Fleet St.		23f. DATE REC'D. BY REGISTRAR 5-20-87	
23g. REGISTRAR'S SIGNATURE		23h. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show only injury, or other traumatic event. The medical examiner must be notified if none.

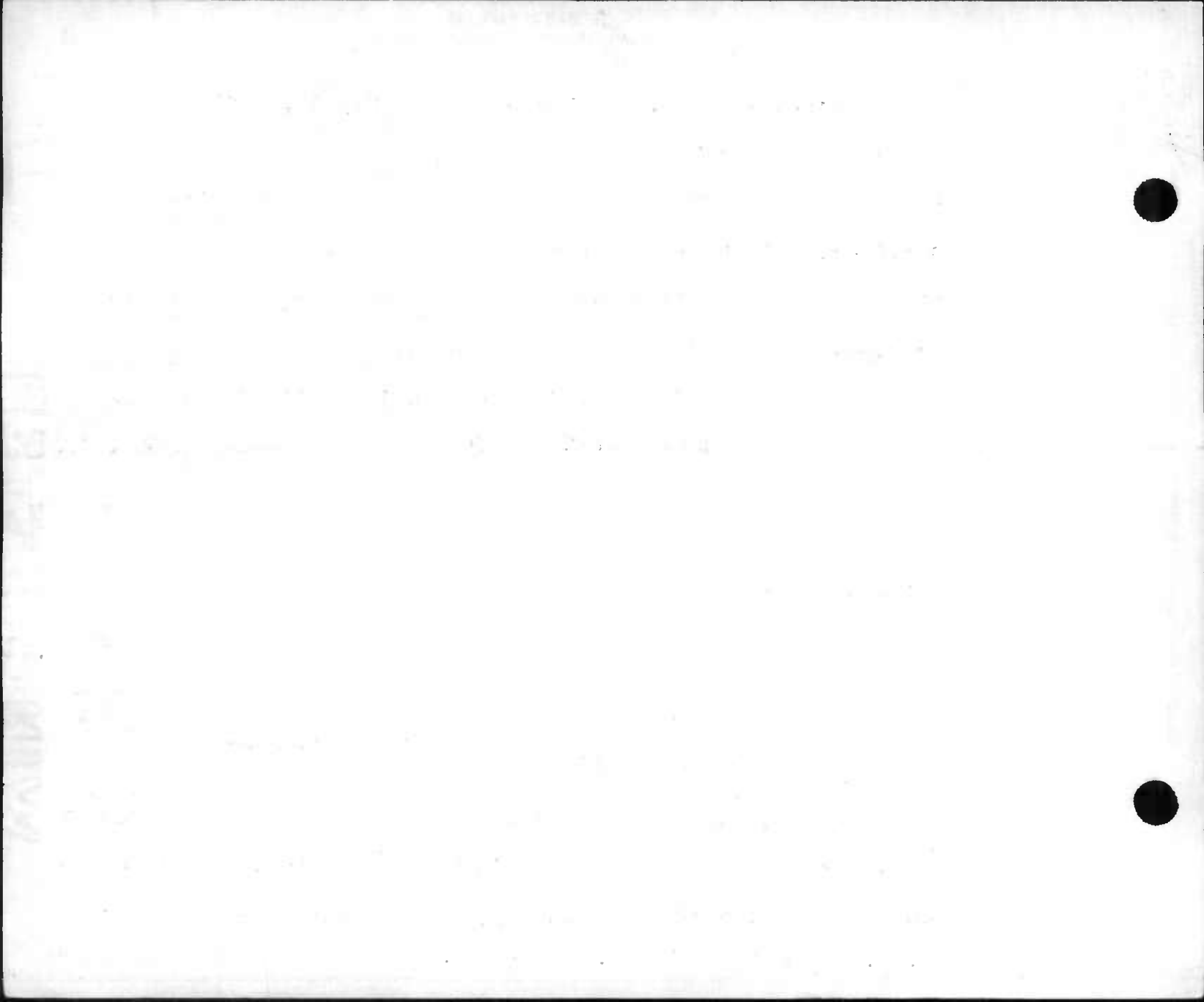
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence G. Dudley			2a. DATE OF DEATH MONTH DAY YEAR May 23, 1987		2b. HOUR M					
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 21 21		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2210 Kirk Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2210 Kirk Ave. 21218	
14 FATHER'S NAME FIRST MIDDLE LAST Lawrence Dudley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Graham							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 224-12-5137		17. INFORMANT ADDRESS Ruthie Dudley 2210 Kirk Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ESOPHAGEAL CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.5 YR		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DEPRESSION</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6 CT</u> , 19 <u>86</u> , to <u>PRESENT</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>APR 21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>GARY CANNON</u>			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/26/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY CANNON			22e. ADDRESS 711 W. 40th BALD MD 21211							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/30/87		23c. NAME OF CEMETERY OR CREMATORY Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE McKenney VA			
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez		

BP



053000 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13449

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLEN R. DUER			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1987		2b. HOUR 12 ⁰⁰ noon	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1892		
6. AGE (IN YEARS LAST BIRTHDAY) 94		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Roland Park Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STREET ADDRESS / ZIP CODE 830 W. 40th St., 21211				
13b. STATE MD		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Robinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Gowen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218 46 0118		17. INFORMANT ADDRESS A. Adgate Duer, Jr., Owings Mills, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>brain stem lesion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>3 mos.</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c. <u>Arterio Sclerosis Cerebrovascular & Coronary Regener. Disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 4</u> , 19 <u>60</u> to <u>May 3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>William F. Fritz</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 5/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William F. Fritz, MD		22e. ADDRESS 2 W. University Pkwy., Balto., MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/2/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD		24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				
25a. DATE REC'D BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Dandridge-Randall</u>				

BP _____

1 JUL 21 1951

From: Mr. J. Edgar Hoover

To: Mr. J. Edgar Hoover

Subject: [Illegible]

Re: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

Q HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical record must be made.

999999

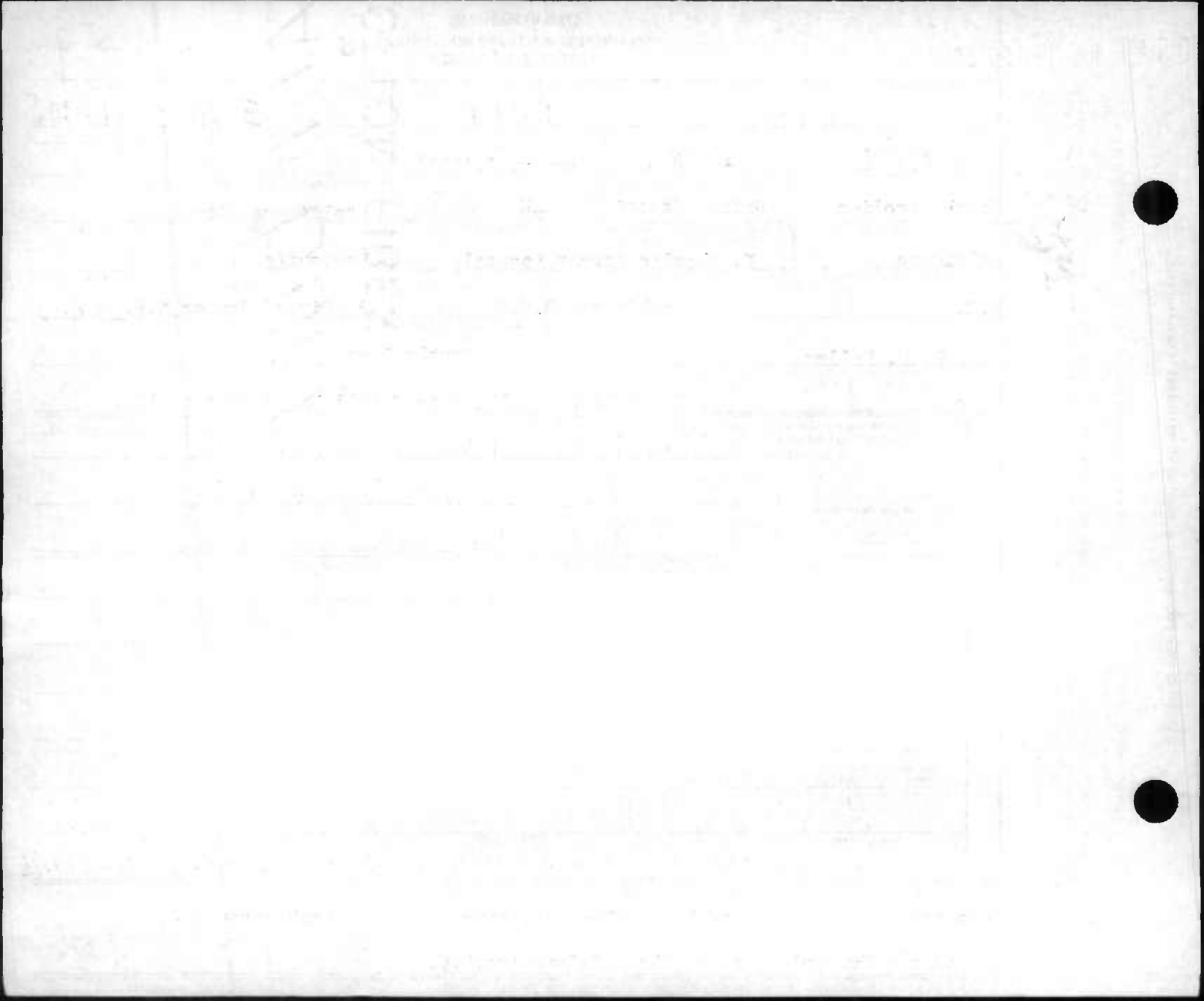
BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 5 0

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE DUFF		2a. DATE OF DEATH MONTH DAY YEAR 5 16 87 2b. HOUR 10:30 ^P	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR January 6, 1892	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Charles Street Hospital	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. KIND OF BUSINESS OR INDUSTRY Housewife		13. CITY OR TOWN Washington, D.C.	
14. FATHER'S NAME FIRST MIDDLE LAST L. M. Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Love	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-84-1128	
17. INFORMANT ADDRESS Wilhemenia Cohill Niece Same as 13e.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CARDIOVASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISEASE, WITH CONGESTIVE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEART FAILURE</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE L. Ceballos, M.D.		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. CEBALLOS M.D.		22e. ADDRESS NORTH CHARLES GENERAL HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 18May87	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home 389 Rhode Island Ave. N.W.		25a. DATE REC'D. BY REGISTRAR MAY 26 1987	
25b. REGISTRAR'S SIGNATURE Julia Gordon-Pedraza			



BP

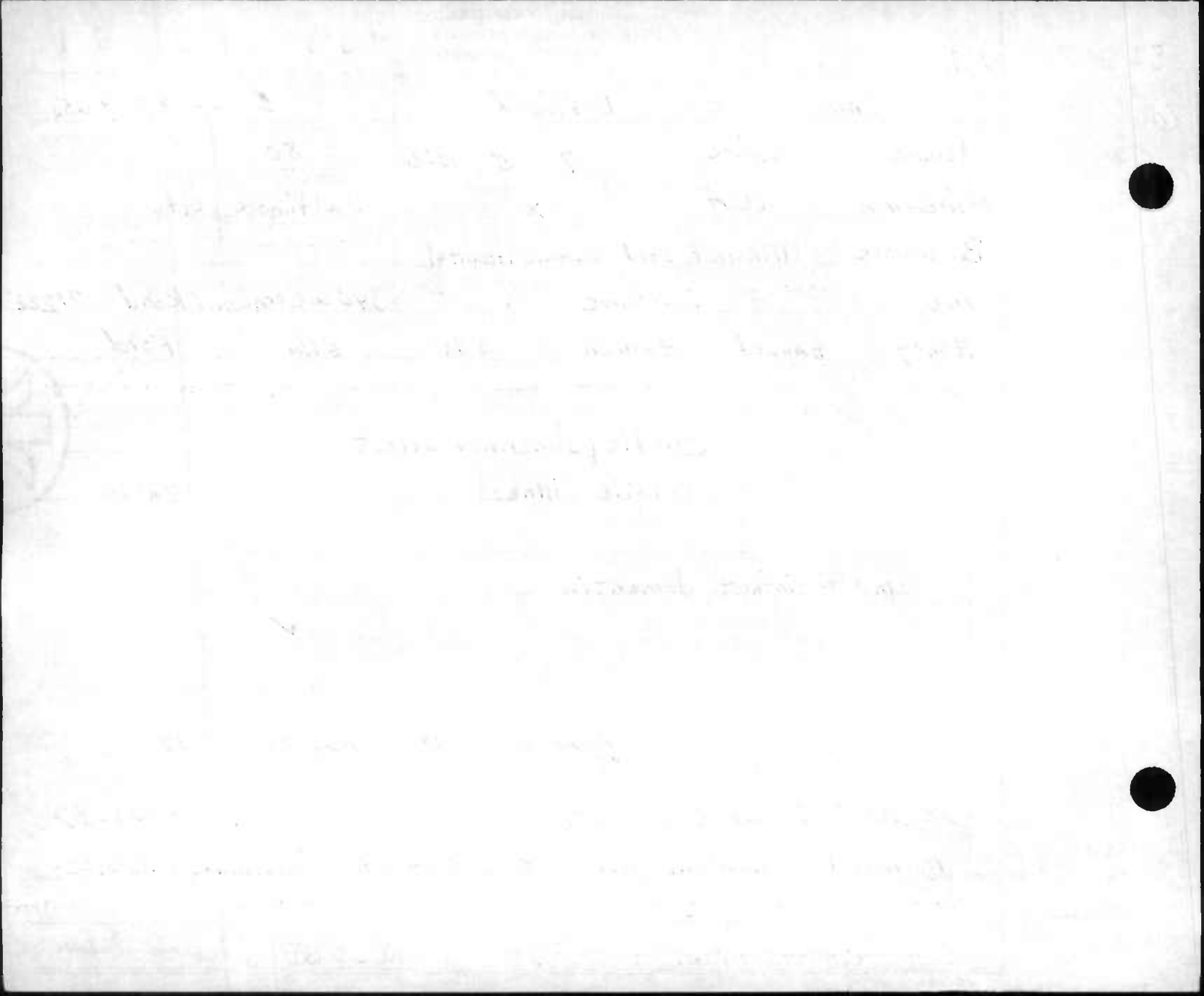
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jane Harmon Duffield					2a. DATE OF DEATH MONTH DAY YEAR 5 23 87				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 5 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		2b. HOUR 9 25A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason F. Lord Chronic Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY Sales	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE mo		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3402 Cornwall Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Hayward Harmon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ELLA Ford		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 218-18-7357		17. INFORMANT ADDRESS Warren C. Thompson, Jr. 4 Abbey Court Bear, Del. 19701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>febrile illness</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Multi-infant dementia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>August 10</u> 19 <u>87</u> to <u>May 23</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 23</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Michele F. Bellantoni</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>5-23-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>michele F. Bellantoni</u>		22e. ADDRESS <u>5200 Eastern Ave. Baltimore, MD 21224</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>May 26, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Walter Brooks Bradley, Inc. Dundalk, Md. 21222</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 26 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Dunder-Rudolph</u>			



054833 JUN - 1 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 3 4 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN LYDIA DUFFY			2a. DATE OF DEATH MONTH DAY YEAR MAY 25 87		2b. HOUR M —
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 11 . 08 . 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	7. UNDER 1 YEAR MONTHS DAYS —
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 632 S. STREEPER ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY —	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 632 S. STREEPER ST. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN RANDALL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA CASEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-18-7015		17. INFORMANT ADDRESS MRS BARBARA BAYNES 643 S. KENWOOD AVE 21224	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Heart Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 yrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

Dehydration & malnutrition

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 3-13 , 19 87 , to 5-24 , 19 87 , that (I) (we) last saw the deceased alive on 5-24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Melito M. Torres		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-28-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melito M. Torres, M.D.		22e. ADDRESS 441 S. Ellwood Ave. Balto. Md. 21224	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-27-87	23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Co. MD
24. FUNERAL DIRECTOR NAME KACZOROWSKI FUNERAL HOME		25. DATE REC'D. BY REGISTRAR 2525 Fleet St 21224	
		26. REGISTRAR'S SIGNATURE MAY 28 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 5 3

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
STEPHENSON J. DUHAN		MAY 28, 1987		6:30P _M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
M	W	4-1-1900	87	BALTIMORE CITY - MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	8. NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	U.S.A.	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	BALTIMORE CITY - MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
BALTO.	CHURCH HOSPITAL	ELECTRICIAN	STATE		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.			BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2501 E. FAYETTE ST 21224
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
ANDREW DUNHAN		FREDERICKA BUDDMEYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		579-05-4237		Mrs. Shirley J. Wilson - 8112 Midhaven Rd. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: MALNUTRITION/DEHYDRATION					
IMMEDIATE CAUSE (a)					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) SENILITY					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
(IF EITHER NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME STREET FACTORY OFFICE FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 27, 19 87, to MAY 28, 19 87 that (I) (we) last saw the deceased alive on MAY 28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
A. F. Nyzemir MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/28/87	
22d. PHYSICIAN'S NAME		22e. ADDRESS			
(TYPE OR PRINT)		CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
(SPECIFY) BURIAL		6-1-87	OAK LAWN Cem.	BALTO., MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME		ADDRESS			
Vestly, John - 7527 Harford Rd.		JUN 1 1987		John Vestly	

BP

13

13

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 5 4

FOR by F.H.,

STATE
REGISTRAR

REG. NO.

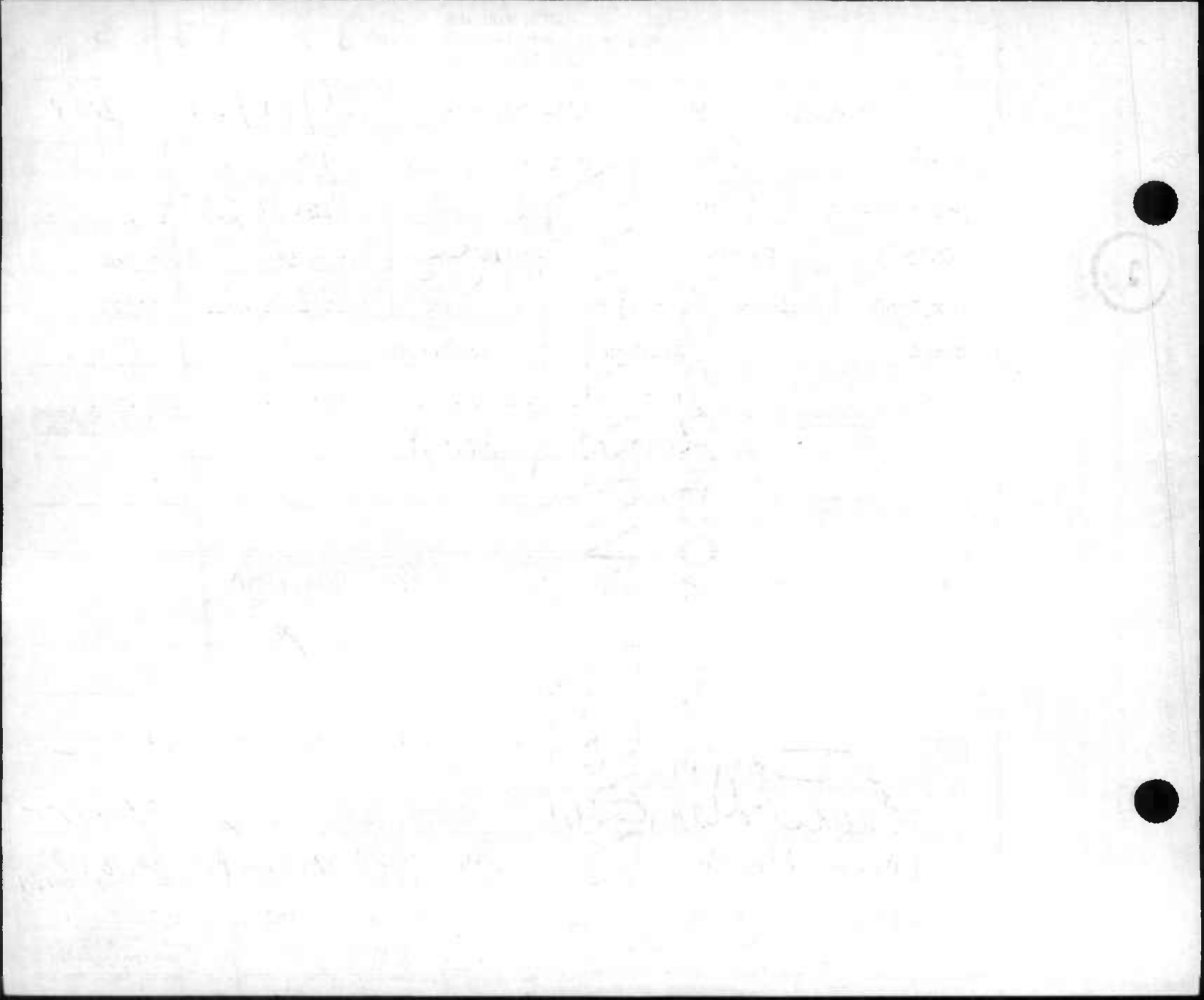
1. DECEASED NAME (TYPE OR PRINT) Catherine M. Dumbrowsky				2a. DATE OF DEATH MONTH DAY YEAR May 14, 1987		2b. HOUR 220 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 14, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ANY) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
						12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						13e. STREET ADDRESS / ZIP CODE 1837 East Ave. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Henri Kaiphass				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kunigunda Nonburger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-10-3613-D			
				17. INFORMANT ADDRESS Dorothy R. Buikstra 7275 Holabird Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Atrial fibrillation, Stage 4 decubitus, END STAGE DEMENTIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from May 13, 1987, to May 14, 1987, that (I) was ^{saw} the deceased alive on May 14, 1987, and that in (my) best ^{best} opinion death occurred on the date and hour and from the causes stated above. (If (you) did ^{did not} view the body after death.							
22b. SIGNATURE Laura Marsh, MD				DEGREE		22c. DATE SIGNED 5/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURA MARSH				22e. ADDRESS FSKMC 4940 EASTERN AVE. BALTO, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-18-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR MAY 18 1987			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



53067 MAY 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13455
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DANIEL MARK DUNAWAY										20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-11-87 ESTI- MATED <input type="checkbox"/> 5-11-87		21. HOUR M 2:55P							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 9 61		6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		22. DATE PRONOUNCED DEAD 5-11-87		23. HOUR 2:55P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland										13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1915 Chipper Drive 21040			
14. FATHER'S NAME FIRST MIDDLE LAST Wes Davis Dunaway										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Stead									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-52-0396				17. INFORMANT Wes Dunaway				ADDRESS 3414 Harmony Church Road Havre de Grace, Md. 21078							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/122 IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:18PM 5-10-87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of a motorcycle/auto collision											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Steven Dr. & Paul Martin Dr. Belair, Maryland											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5-12-87							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY Deer Creek Harmony Presby.				23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.									
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A. Aberdeen, Md. 21001-3399																			
25a. DATE REC'D. BY REGISTRAR MAY 15 1987																			
25b. REGISTRAR'S SIGNATURE [Signature]																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Dolores DUNN</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>5 5 87</i>					2b. HOUR <i>924 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-22-1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>YRS</i>		8. IF UNDER 24 HRS HOURS MIN. <i>924 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WilkesBarre, PA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD</i>					
10. CITY OR TOWN OF DEATH <i>Balto. City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Upholsterer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Martin Marlite</i>			
13a. STATE <i>MD</i>			13b. COUNTY <i>Balto. City</i>		13c. CITY OR TOWN <i>Balto. City</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4702 Eugene Ave., Balto. 21206</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Lehman</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaretta Connolly</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>182-16-8005</i>		17. INFORMANT ADDRESS <i>James A. Dunn, 9418 Bellhall Drive, Balto. 21236</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Extensive Myocardial Infarction & heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c)										<i>5 days.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>NO</i>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>4/50</i> 19 <i>87</i> to <i>5/5</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>5/5</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. Oshida MD</i>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/5/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Oshida MD</i>					22e. ADDRESS <i>Good Samaritan Hospital</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5-8-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Memorial</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Balto., MD</i>			
24. FUNERAL DIRECTOR NAME <i>John C. Miller, Inc., 6415 Belair Rd., 21206</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 8 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements. It is shown that the theory of the structure of the atom can be used to explain the periodicity of the elements, and that it can be used to predict the properties of the elements.

3. The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the compounds. It is shown that the theory of the structure of the atom can be used to explain the properties of the compounds, and that it can be used to predict the properties of the compounds.

55636 JUN-5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13457

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY MIDDLE L. LAST DUNN			2a. DATE KNOWN OF DEATH MONTH DAY YEAR MATED <input checked="" type="checkbox"/> 5-29-87 19			2b. HOUR M am 10:15										
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 29 10		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-29-87 19			7d. HOUR am 10:15				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ala.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 922 Rutland Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 922 N. Rutland Ave. 21205			
14. FATHER'S NAME FIRST MIDDLE LAST Anderson Clark						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary B. Dukes													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 567-28-7259				17. INFORMANT ADDRESS Oliver Dunn 922 Rutland Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Margie McKrell</u>						TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER						DATE SIGNED 5-29-87							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/4/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD									
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR JUN 3 1987				25b. REGISTRAR'S SIGNATURE Julia Barber-Kandash									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George J. Eckenrode		2a. DATE OF DEATH MONTH DAY YEAR April 19, 1987		2b. HOUR 8:10 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-13-1893		6. AGE (IN YEARS (LAST BIRTHDAY)) 93 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Printer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1130 Sherwood Ave. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI	17. INFORMANT ADDRESS 215-01-7628A Norman D. Heath, Same as 13e			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recurrent Carcinoma of the Bladder</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>4/19/87</u> to <u>4/19/87</u> , that (I) (we) lost saw the deceased alive on <u>4/19/87</u> , and that in (my) (our) opinion death occurred on the date and had and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Albert B. Bradley</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/20/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert B. Bradley, M.D.		22e. ADDRESS 4900 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 4-21-87	23c. NAME OF CEMETERY OR CREMATORY Westview	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.		25a. DATE REC'D. BY REGISTRAR APR 20 1987		25b. REGISTRAR'S SIGNATURE <u>Julia T. Ruck</u>	

BP

052634 MAY - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 + 3460

REG. NO.

FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
WILLIAM H. ECKMEYER		MAY 3 1987		5 3 87		11:5 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Male	White	Mar. 3, 1918	69 YRS.	MD		USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
		Baltimore City MD		Baltimore		Union Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
Salesman		Heavy		MD		Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
William C. Eckmeyer		Bertha Kline		No		219 03 0449	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident, Massive</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Senia E. Eckmeyer,		Same					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1 87, to 5/3 87, that (I) (we) (we) saw the deceased alive on 5/3 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
S.O. TREBETOLA MD		MD		5/3/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
S.O. TREBETOLA MD		Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		5/5/87		Oak Lawn		Balto., MD	
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.		MAY 4 1987		Jillie Gordon-Rodden			
4905 York Road Balto., MD 21212							

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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USA

17

1. *Introduction*

[illegible]

52929 MAY 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

1 3 4 6 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) THELMA T. EDWARDS			2a DATE OF DEATH MONTH DAY YEAR 5-3-87		2b HOUR MIN 4:31 A
3 SEX F	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 4 28 51	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 36		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD	13b COUNTY MD	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2529 Salem St. 21217	
14 FATHER'S NAME FIRST MIDDLE LAST Richard Edwards		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Pate			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-56-4479		17 INFORMANT ADDRESS Zelma Edwards 1983 Bloomfield Drive	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) R/O SEPTIC EMBOLI					
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA, HEPATITIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a R/O MALIGNANCY, JAUNDICE					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 5-2-1987 , to 5-3-1987 , that (I) (we) last saw the deceased alive on 5-3-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Anil N. Raiker		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 5-3-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER		22e ADDRESS Liberty Medical Center			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/9/87	23c NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24 FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a DATE REC'D. BY REGISTRAR MAY 8 1987	
				25b REGISTRAR'S SIGNATURE John Gordon-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

THE COUNTY LIBRARY

WILLIAM BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT) Elizeb-h					2a. DATE OF DEATH MONTH 05 DAY 12 YEAR 1987					2b. HOUR 1-30 P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 11 DAY 19 YEAR 92		6. AGE (IN YEARS (LAST BIRTHDAY)) 94 YRS.			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY BALTO.CO.		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3004 CALIFORNIA AVE 21234				
14. FATHER'S NAME FIRST WILLIAM MIDDLE F. LAST BEALL					15. MOTHER'S MAIDEN NAME FIRST KATHERINE MIDDLE LAST WEHR							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-05-7224		17. INFORMANT FAMILY RECORDS								
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung metastatic										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) to liver		
DUE TO, OR AS A CONSEQUENCE OF (c) 												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension												
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/1/87 19 87 to 5/11/87 19 87 that (I) (we) last saw the deceased alive on 5/19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Matun N. Naem					DEGREE 			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/13/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MATUN N. NAEM					22e. ADDRESS 501 Dolphin St, Balto MD 21217							
23a. BURIAL CREMATION REMOVAL BURIAL			23b. DATE 5-15-1987		23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CITY MD.				
24. FUNERAL DIRECTOR EVANS CHARL OF MEMORIES					25a. DATE REC'D. BY REGISTRAR MAY 20 1987			25b. REGISTRAR'S SIGNATURE Jessie J. J. J.				

1

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible text follows]

052998 MAY 17

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

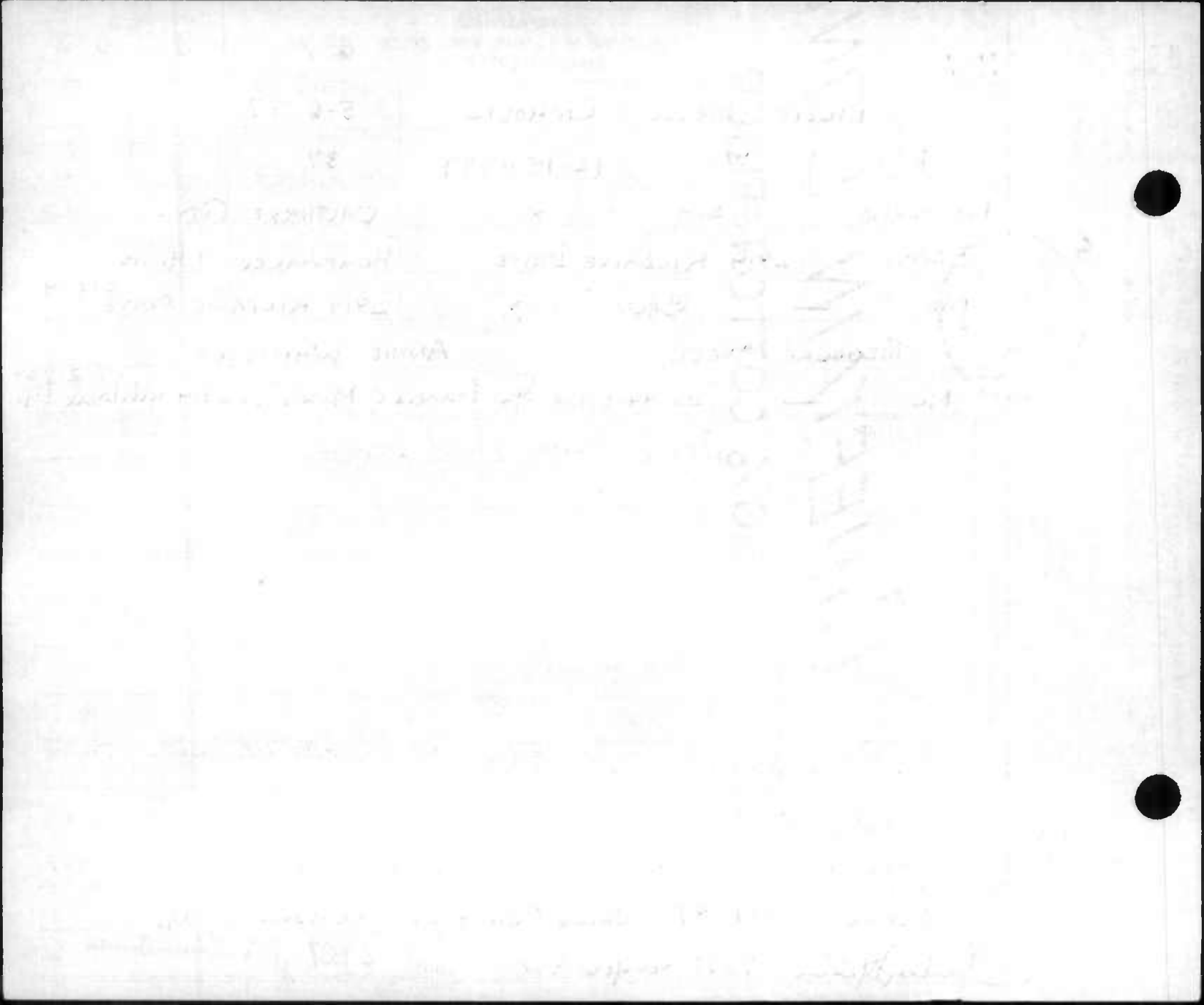
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13463

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIE BELLE EICHOLTZ			2a. DATE OF DEATH MONTH DAY YEAR 5-6-87		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12-15-1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY - MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2819 KILDAIRE DRIVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE MD.		13b. COUNTY 	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE ANGEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE WHITMORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-44-0195A		17. INFORMANT ADDRESS Mrs. Frances C. Marshall - 2814 Kildaire Dr. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR April 27 1987 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 27 1987 to April 27 1987 , that (I) (we) last saw the deceased alive on April 27 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janet H. Greenhut		DEGREE MD		22c. DATE SIGNED 5/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet H. Greenhut		22e. ADDRESS 4215 Loch Raven Blvd, Balto 21213			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-9-87		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE KEYESVILLE MD.		25a. DATE REC'D. BY REGISTRAR MAY 8 1987			
24. FUNERAL DIRECTOR NAME Janet H. Greenhut		ADDRESS 7527 Hayford Rd.		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

053951

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 13464	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMA NAOMI EISNER					2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1987			2b. HOUR P. 9:30 M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 20 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY DRUG STORE			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4000 DUDLEY AVE. 21213			
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN GAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE SICKEL			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 214-16-9899			17. INFORMANT ADDRESS NORMA FOSTER (DGHTER) 33 EBBING COURT 21221								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarctio</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1976</u> to <u>my 10th</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>my 10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>I Che</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ISSAM CHEIKH						22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/18/87		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.				
24. FUNERAL DIRECTOR SCHMIDTKE FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR MAY 10 1987		25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>			

BP

THE UNIVERSITY OF CHICAGO
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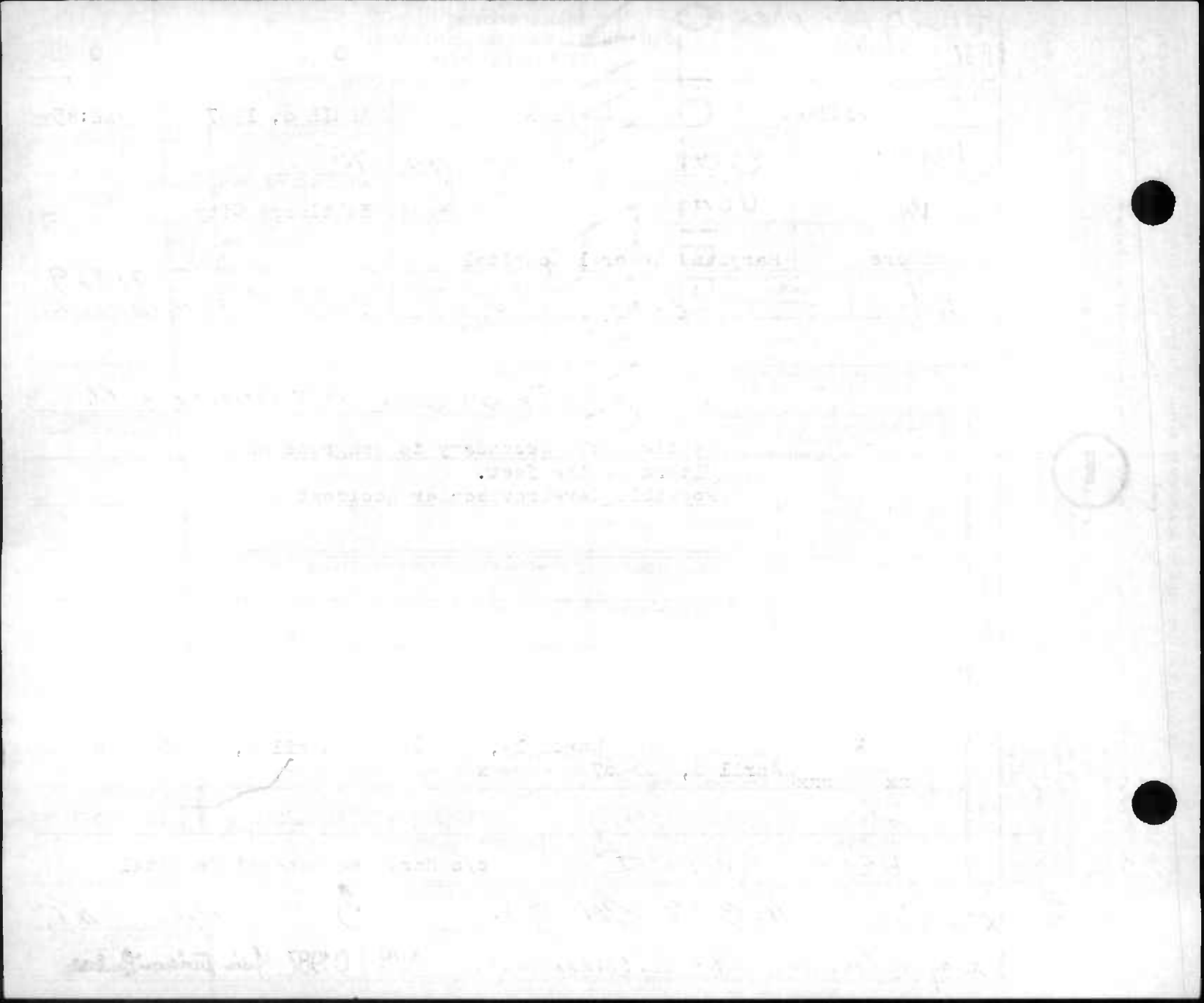
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13 per phone
FOR 5/18/87
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13465
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD ELAM			2a. DATE OF DEATH MONTH DAY YEAR APRIL 8, 1987		2b. HOUR 12:45am
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 29 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-01-0299		17. INFORMANT ADDRESS Thomas Green 4419 Old Frederick Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock Secondary to Gangrene and Ulcers of the feet. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Possible Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from March 19, 1987 to April 8, 1987 , that (b) (we) last saw the deceased alive on April 8, 1987 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (not) view the body after death.					
22b. SIGNATURE Henri Nammoor M.D.		DEGREE		22c. DATE SIGNED 4-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRI NAMMOOR		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-13-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME Dorey M. Leland		ADDRESS 3405 W. Franklin St.		25a. DATE REC'D. BY REGISTRAR APR 10 1987	
				25b. REGISTRAR'S SIGNATURE Julia Simon-Randall	



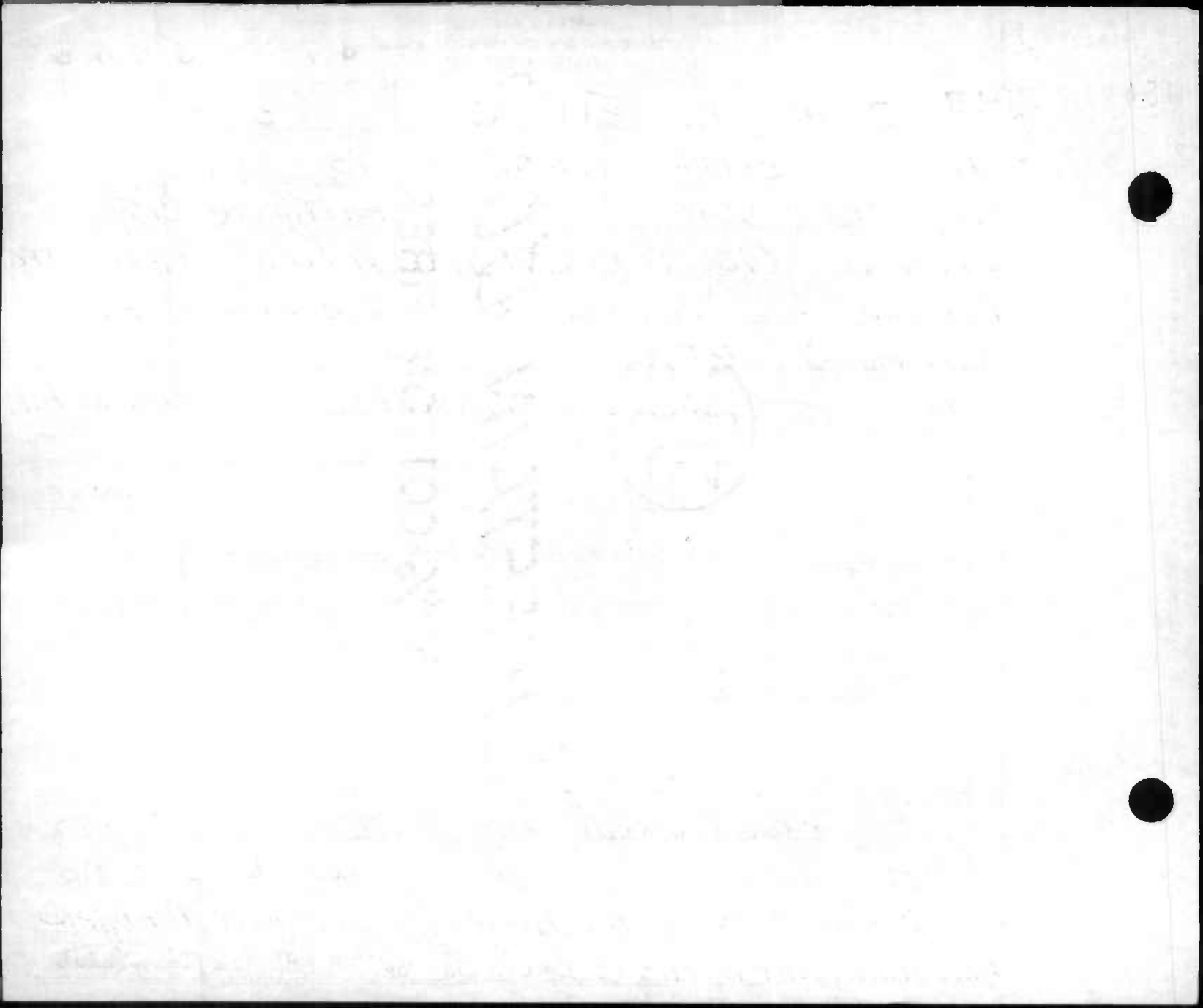
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 3 4 6 6

1. DECEASED NAME (Type or Print)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
James M. Elliott				5-24-87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Black	12-28-13		73		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or Foreign Country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Crapo, Md	USA			BALTIMORE City				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If now in such facility, give street address)		12a. USUAL OCCUPATION (Type of work for most of working life)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Liberty Medical Center		Retired		Steelworker				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2935 Belmont Ave.				21216	
14. FATHER'S NAME (Type or Print)		15. MOTHER'S MAIDEN NAME (Type or Print)							
William J. Elliott		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		226-10-6578		MARGARET ELLIOT		2935 BELMONT AVE.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sudden death</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>Yr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE KINDS OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION		CITY OR TOWN		COUNTY	STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
ALAN L. Kimmel				MD				5/26/87	
22d. PHYSICIAN'S NAME (Type or Print)				22e. ADDRESS					
ALAN L. Kimmel				220 W. Colospeng Lane 21216					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN	
BURIAL		5-30-87		MT. AUBURN Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
BROWN/THOMPSON F.H.				1913 W. BALTO. ST		MAY 28 1987		Julia Davidson-Randall	



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052043 MAY 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

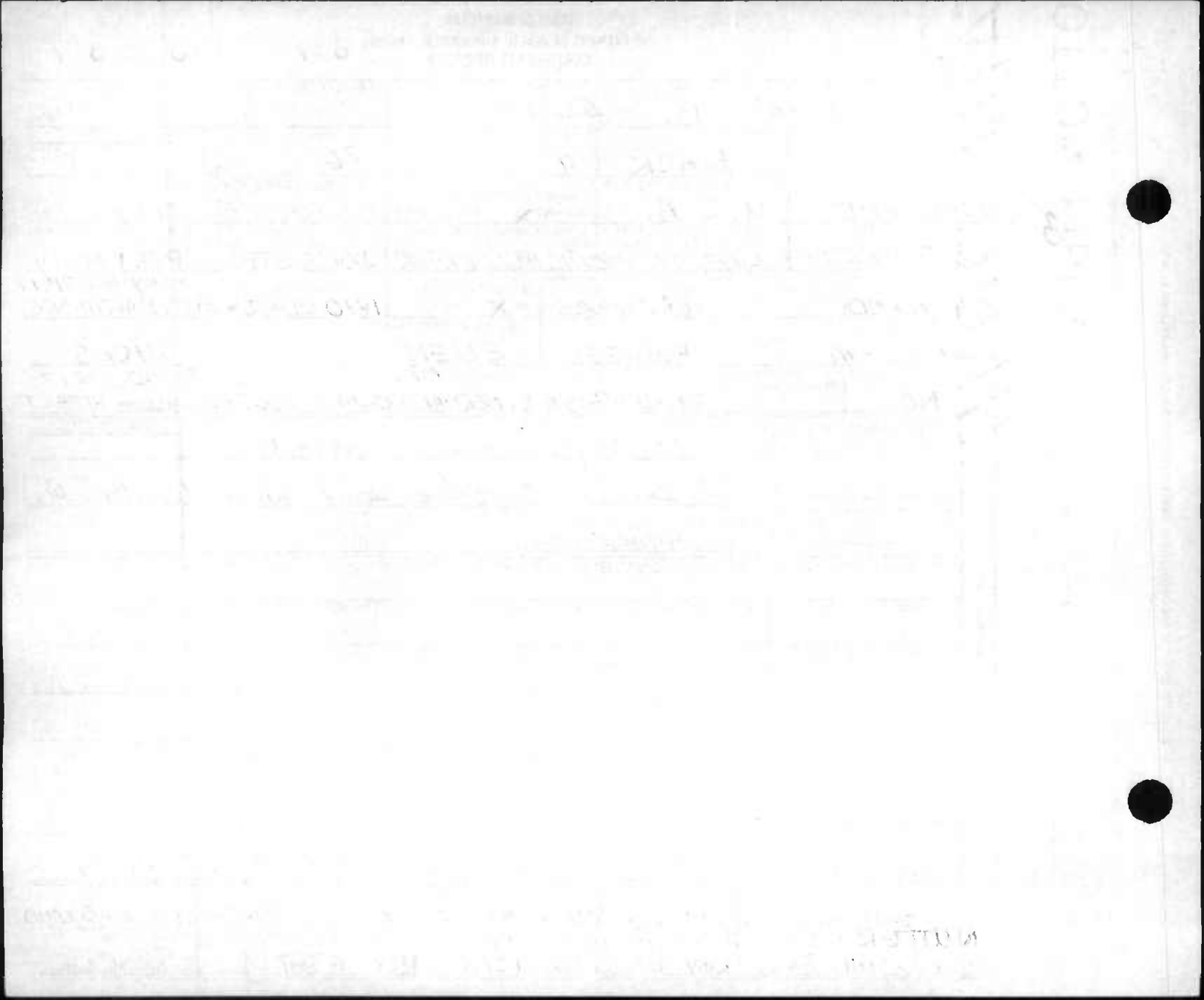
87

REG. NO.

13461

1. DECEASED NAME (TYPE OR PRINT) LILLIAN B. ELLIS				2a. DATE OF DEATH MONTH 5 DAY 3 YEAR 87				2b. HOUR 7:05 PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 9 DAY 5 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1810 CUFTON AVE, BALTIMORE, MARYLAND 21217	
14. FATHER'S NAME FIRST WILLIAM MIDDLE BURGESS LAST BURGESS		15. MOTHER'S MAIDEN NAME FIRST ELLEN MIDDLE HICKS LAST HICKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-9115A		17. INFORMANT MR. E. BERNARD BLAKE ADDRESS BALTO. MD. 21217 2007 McCULLOH STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-29 , 19 87 , to 5-3 , 19 87 , that (I) (we) last saw the deceased alive on 5-3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sher A Hashmi				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHER AFZAL HASHMI				22e. ADDRESS 2600 LIBERTY HEIGHTS AVE 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/8/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK.		23d. LOCATION CITY OR TOWN BALTIMORE, MARYLAND COUNTY STATE			
24. FUNERAL HOME NOTER + SONS FUNERAL HOME, INC.				25a. DATE REC'D. BY REGISTRAR MAY 6 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudman			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13468

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES FRANKLIN ELLISON				2a. DATE OF DEATH May 5 1987		2b. HOUR 8:55 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH 7 16 42		6. AGE (IN YEARS LAST BIRTHDAY) 44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rock Hill, S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE REFERENCE BEFORE ADMISSION) Baltimore MD		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS ZIP CODE 3029 Oakley Avenue 21215	
14. FATHER'S NAME FIRST Maxie MIDDLE LAST Ellison		15. MOTHER'S MAIDEN NAME FIRST Canzell MIDDLE LAST Washington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. U.S. ARMY OR NAVY SERVICE NUMBER (IF YES, GIVE WAR OR DATES) 215-40-3088		17. INFORMANT ADDRESS Rosalie Ellison 3029 Oakley Avenue 21215			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Metastatic Pancreatic Ca.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

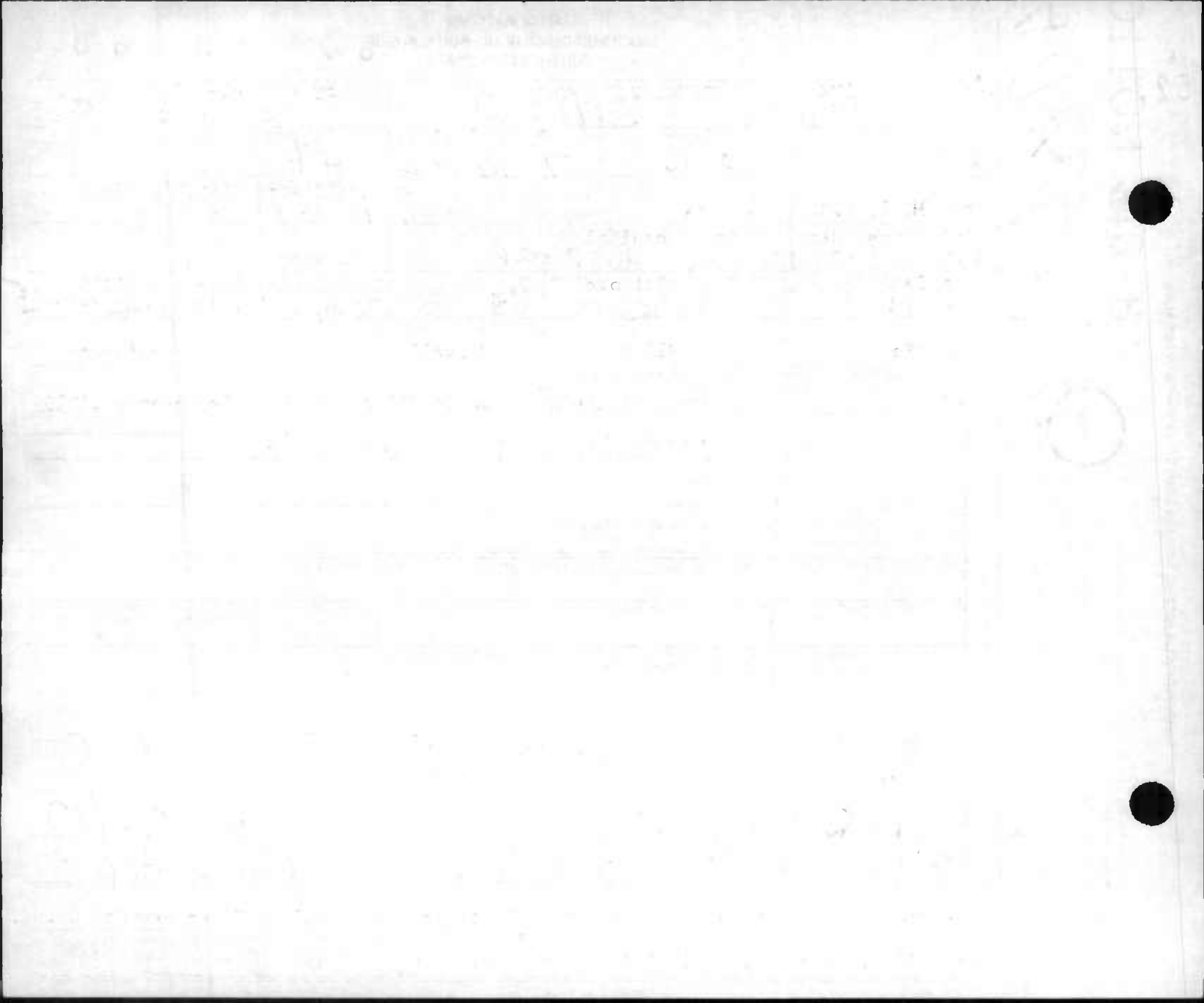
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1/87 to 5/1/87 , that (I) (we) last saw the deceased alive on 5/1/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did not) view the body after death.)							
22b. SIGNATURE Marshall W. Jones, Jr.				DEGREE MD		22c. DATE SIGNED 5/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall W. Jones, Jr.				22e. ADDRESS Belvedere at Green Spring			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr. ADDRESS FH 4101 Edmondson Ave.				25a. DATE REC'D. BY REGISTRAR MAY 4 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rodgers	

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055458 JUN 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 4 6 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR			
DAVID		EPSTEIN						MAY 29, 1987										12:30P ^{PM}			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		CAUCASIAN CAUCASIAN		FEB. 25, 1900		78 YRS.						MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
NEW JERSEY		USA				BALTIMORE CITY												MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
BALTIMORE		1190 W. NORTHERN PKWY, APT. 616		PHARMACIST		DRUGS															
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1190 W. NORTHERN PKWY, APT. 616												(21210)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
MORRIS		IDA																UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		144-22-2065A		MRS. MYRA E. MYERS		5910 EASTCLIFF DR. 21209															
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15/87</u> to <u>5/29/87</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.																					
22b. SIGNATURE		22c. DATE SIGNED																			
DR. J. LEONARD LICHTENBERG		2435 W. BELVEDERE AVE.																			
23a. BURIAL, CREMATION, REMOVAL (5) BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
MAY 31, 1987		BALTIMORE HEBREW CHM- REISTERSTOWN BALTO.																			
24. FUNERAL DIRECTOR NAME		25a. DATE BY REGISTER SIGNATURE																			
SOL LEVINSON & BROS., INC.		JUN 3 1987																			
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215																					

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 7 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARION	MIDDLE MUNSON	LAST EVANS	2a. DATE OF DEATH MONTH DAY YEAR 5/18/87		2b. HOUR 800p M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 08 24 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NJ	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH CITY BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST ANNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1303 MIDDLEFORD ROAD CATONSVILLE 21228		
14. FATHER'S NAME FIRST MIDDLE LAST LEVI MUNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE FUHRMANN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 212-74-9842		17. INFORMANT MARJORIE MELICK		ADDRESS 1303 MIDDLEFORD ROAD CATONSVILLE, MD. 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVP</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>hrs</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> 19 <u>87</u> , to <u>5/18</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Grone MD</u>				DEGREE MD		22c. DATE SIGNED 5/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Grone MD				22e. ADDRESS St. Agnes Hos, BALTIMORE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/27/87		23c. NAME OF CEMETERY OR CREMATORY WALLKILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WALDEN NEW YORK	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228				25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Seaton-Baker	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

BP

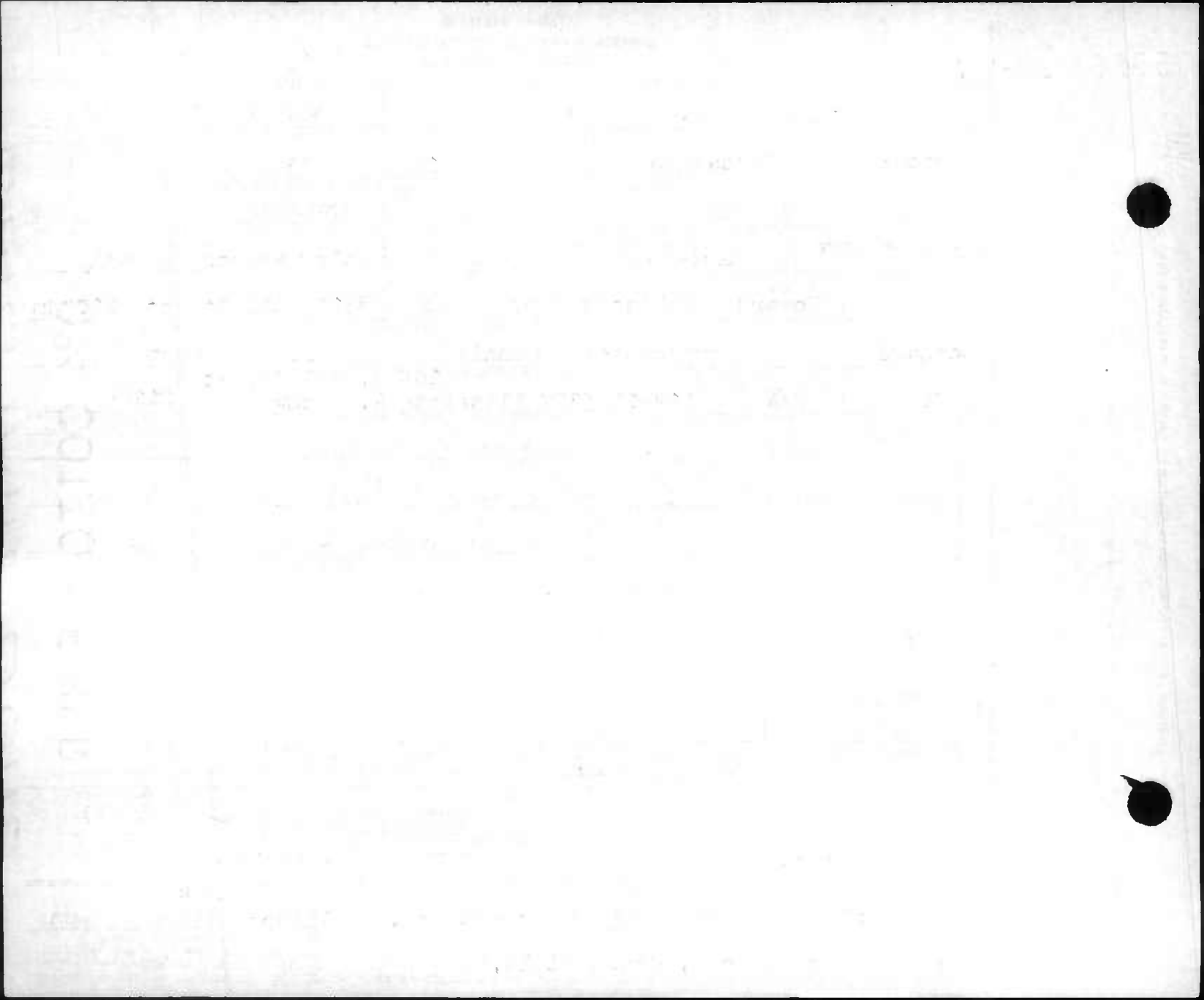
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13471

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SELMA E. EVERSMEIER			2a. DATE OF DEATH MONTH DAY YEAR 5/28/87 05 28 87		2b. HOUR 0730 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 09 09 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Person		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE MD			13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Eversmeier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Kopp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 105 S. Rolling Road Elizabeth A. Klemm 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Cardiac Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES hours years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Pt. was in a very poor nutritional status</u>					
19a. DATE OF OPERATION 5/13/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Crohn's Disease</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> , 19 <u>87</u> , to <u>5/28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>D. Rocha MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOMINGO ROCHA, M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-30-87		23c. NAME OF CEMETERY OR CREMATORY Good Shepard Cem.	
23d. LOCATION CITY OR TOWN Ellicott City		23e. COUNTY Howard		23f. STATE MD	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, Catonsville, MD			25a. DATE REC'D. BY REGISTRAR JUN 2 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Swenson-Rodgers</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 13472

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Albert J. Trageser Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 5 1987</i>		2b. HOUR <i>12</i>
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7/8/12</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>	7b. CITIZEN OF WHAT COUNTRY? —	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>600 Light St. 21230</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i>	13c. COUNTY —	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>600 Light St. 21230</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Trageser</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Dorsey</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)	17. INFORMANT ADDRESS <i>600 Light St. 21230</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 d</i>
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <i>11-20</i> , 19 <i>82</i> , to <i>5-5</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>12-26</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <i>John L. Pinner MD</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>5/5/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MAJC S. PINNER MD</i>			22e. ADDRESS <i>107 E. WEST ST.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>5/8/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>615 Light St. 21230 Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Charles L. Stevens</i>			25. DATE REC'D BY BALTIMORE REGISTRAR <i>MAY 7 1987</i>		

BP

ST-81

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7

054093 MAY 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13473

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

John A. FAISON

2a. DATE OF DEATH MONTH DAY YEAR

5-15-87

2b. HOUR

M

3. SEX

male

4. RACE

Col

5. DATE OF BIRTH

8 7 28

6. AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Greene Co. N.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

505 N. Schroeder St

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

BALTO.

13c. CITY OR TOWN

YES ☒ NO ☐

13d. STREET ADDRESS / ZIP CODE

505 N. Schroeder St 21217

14. FATHER'S NAME

William

MIDDLE

LAST

FAISON

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

Foulkes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

237-361184

17. INFORMANT

Mr. William Faison 1601 N. Washington St 21213

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma of Bladder

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Renal failure

19a. DATE OF OPERATION

11/8/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

J. B. Faison Bladder

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/11/87, to 4/1/87, that (I) (we) lost

saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

Attending Physician

MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

5/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

B. I. OPARA

22e. ADDRESS

2300 Garrison Blvd Baltimore, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

5-21-87

23c. NAME OF CEMETERY OR CREMATORY

Garrison Forest Mt. Cen.

23d. LOCATION

CITY OR TOWN

BALTO. Co.

COUNTY

STATE

24. FUNERAL DIRECTOR

Joseph L. Russ 2222 W. North Ave.

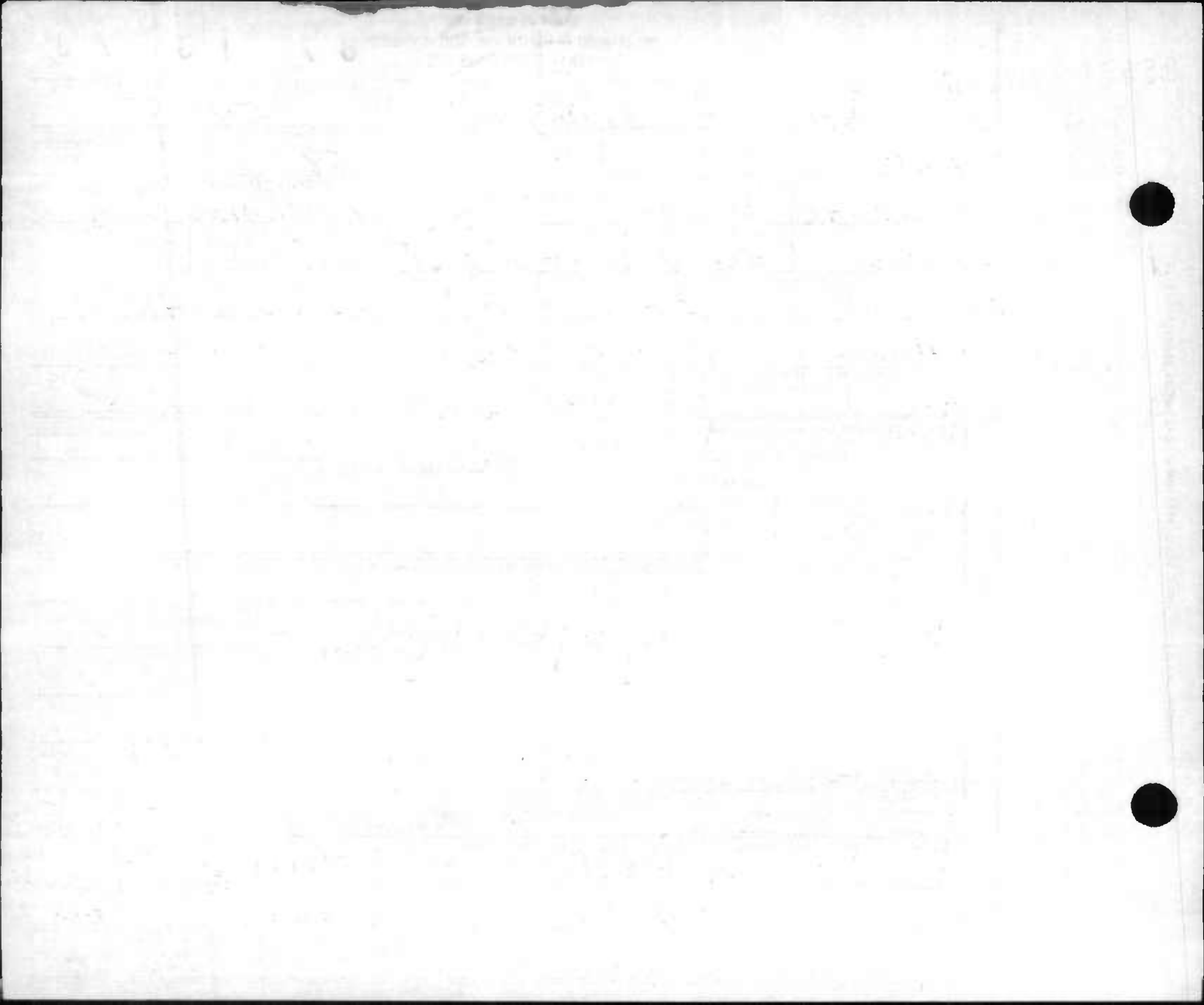
25a. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAY 20 1987 Julia Davidson-Peterson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

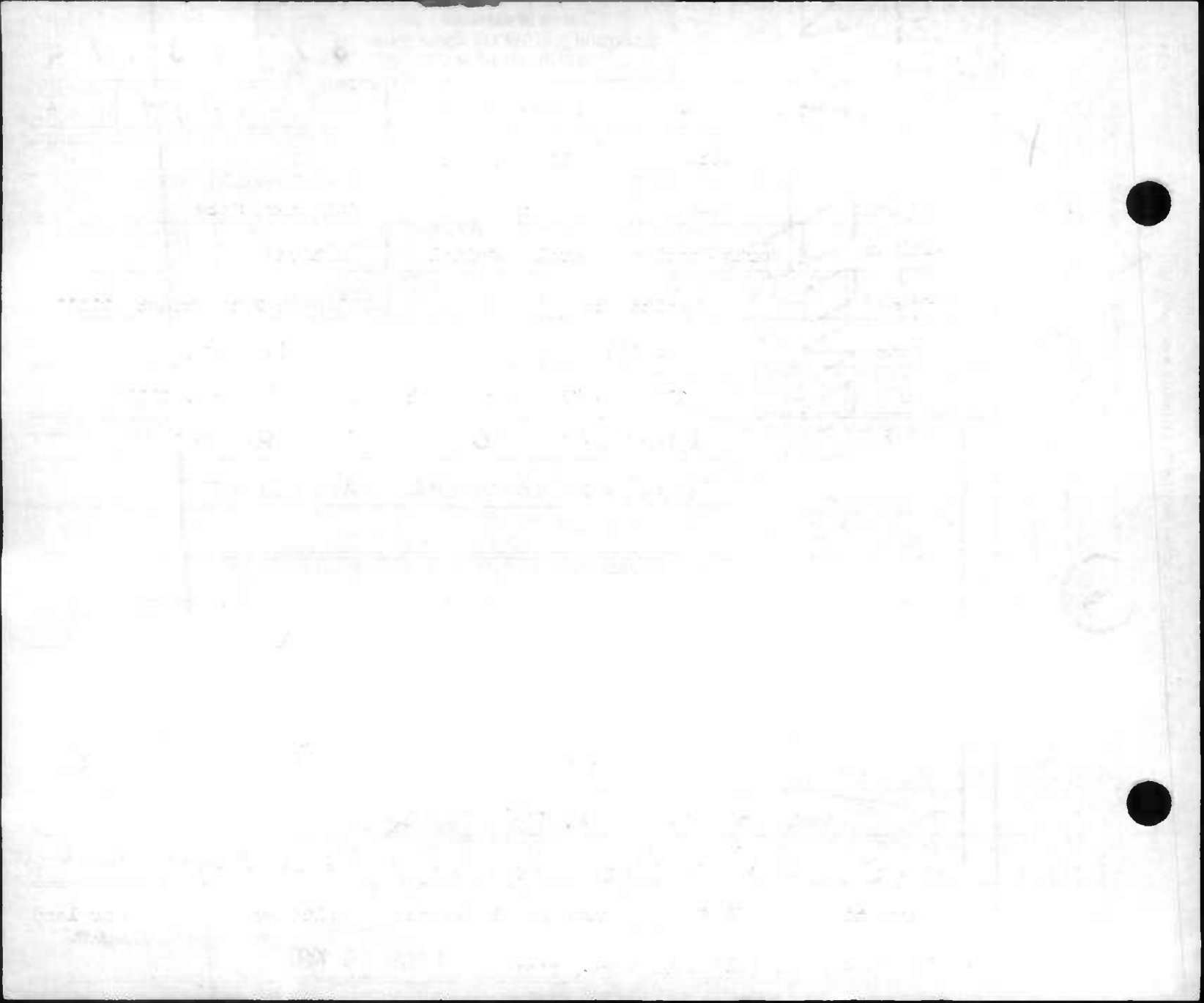
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13474

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JAMES L. FANWELL					5	13	87		11:15 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	MONTH DAY YEAR 12 23 19		67		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Baltimore City				MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	North Charles General Hospital		Retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		331 West 27th Street 21211	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Oscar Fanwell		FIRST MIDDLE LAST (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		215-09-9033		Raymond Stine		1014 Union Ave.		21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				4/21 19 87 to 5/13 19 87					
22a. I certify that (I) (this hospital) attended the deceased from 4/21 19 87 to 5/13 19 87, that (I) (we) lost saw the deceased alive on 5/13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED			
A. C. ENRIQUE		MD		PHYSICIAN					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
A. C. ENRIQUE		2435 W. BELVEDERE		21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		5/15/87		Green Mount Cemetery		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A. Alan Seitz, Jr.				3818 Roland Ave.		MAY 14 1987			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13475
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARL C. HARRELL FAUNTIEROY		2a. DATE OF DEATH MONTH DAY YEAR May 17 1987		2b. HOUR 12:59AM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9 7 27		6. AGE (IN YEARS LAST BIRTHDAY) 59 IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE VIRGINIA	13b. COUNTY HAMPTON	13c. CITY OR TOWN HAMPTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 26 BOOKER ST. 23663	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CHARITY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MANNIE CHARITY ST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 231-28-1828		17. INFORMANT ADDRESS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cardiac Disease - DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes, Heart Disease -					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4 87, 19 86, to 5 87, that (I) (we) last saw the deceased alive on 4 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Cevallos		22c. DATE SIGNED 5/19/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Cevallos	
22e. ADDRESS University of Maryland Hospital		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL	23b. DATE 5-19-87	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAMPTON VIRGINIA	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS		24b. ADDRESS 1721-27 N. MONROE ST.		25a. DATE RECEIVED BY REGISTRAR MAY 28 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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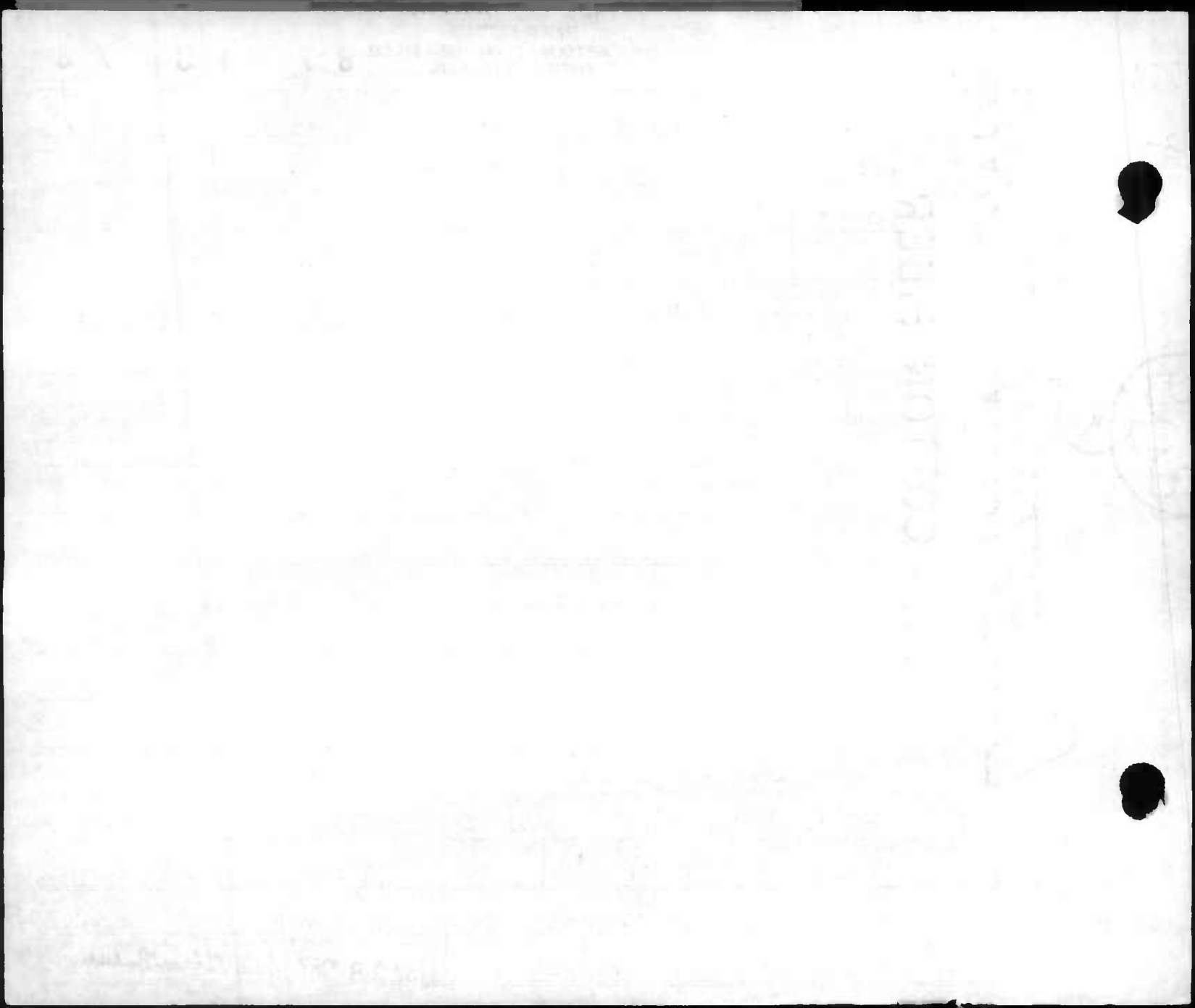
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13476

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Willimina G. Fearn		2a. DATE OF DEATH MONTH DAY YEAR 5-25-87		2b. HOUR 8:30 PM	
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9-15-00	
7a. BIRTHPLACE (COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? US		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST William Fearn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Malchoim			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-01-0628		17. INFORMANT Dorothy A. Richardson, Lodi, California	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe Malnutrition.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 30th 1987, to May 25th 1987, that (I) (we) lost saw the deceased alive on May 25th 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John A Tygart		DEGREE MD		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A TYGART		22e. ADDRESS 3001 S. (BETHRA) Harrow St, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland		23f. STATE	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR MAY 28 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Ruders					



053936 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 1 3 4 7 1

1. DECEASED NAME (TYPE OR PRINT) MARY V FELDMAN			2a. DATE OF DEATH MONTH DAY YEAR 5 14 87			2b. HOUR 900 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 20 99		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT. GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME MAKER	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Albert George Bozek		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patranella Nagaska		13e. STREET ADDRESS / ZIP CODE 7303 Green Acres Dr 21061					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-22-3117		17. INFORMANT Rita Bozek		ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Rep Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno CA c metastatic Disease DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE Cardiovascular Dz APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic obstructive pulm Dz; SENILE DEMENTIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael Kazak				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK				22e. ADDRESS 3001 S. HAMNER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/16/87		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md			
24. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodak	

MEDICAL CERTIFICATION

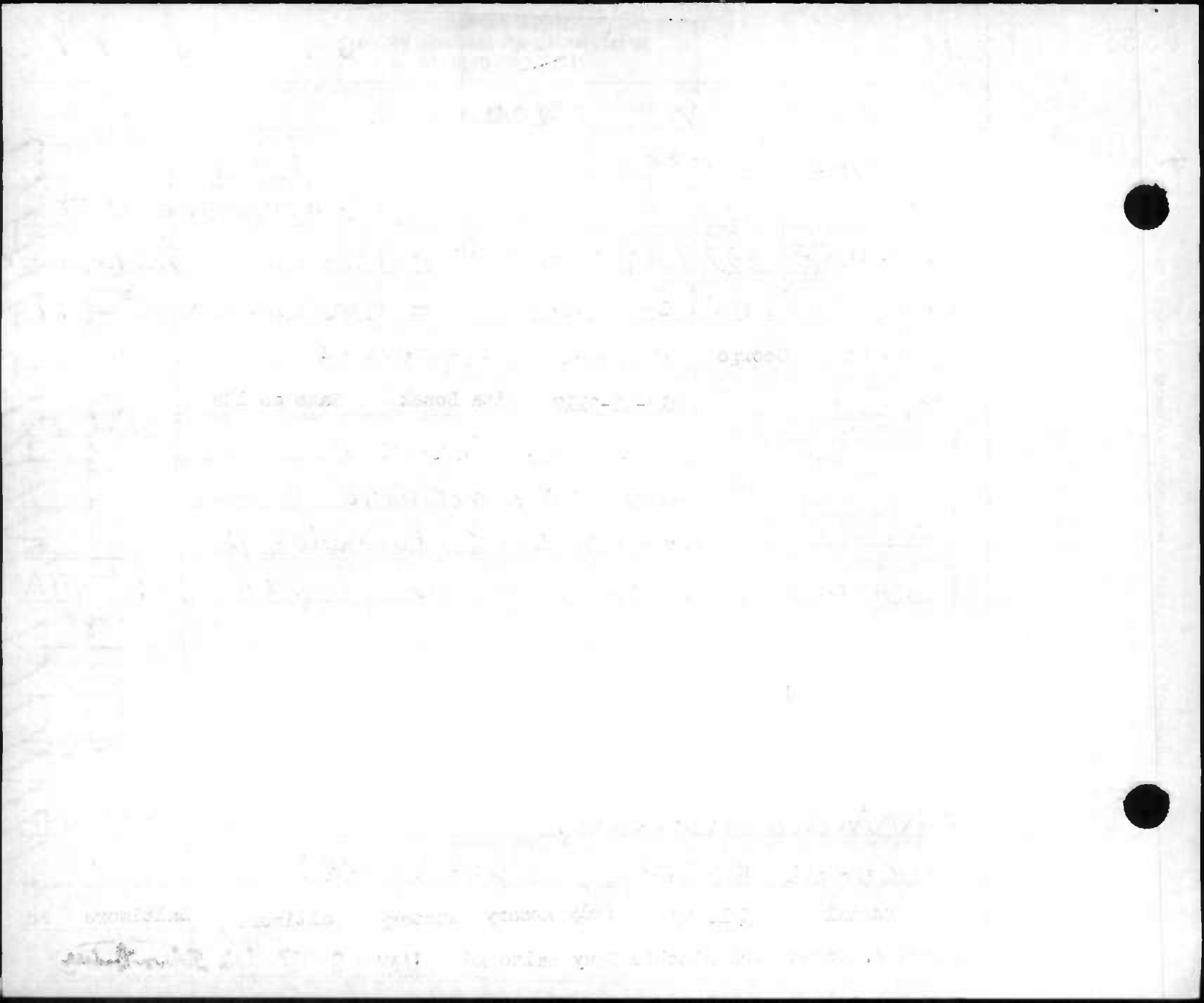
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or the 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



54673 MAY 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

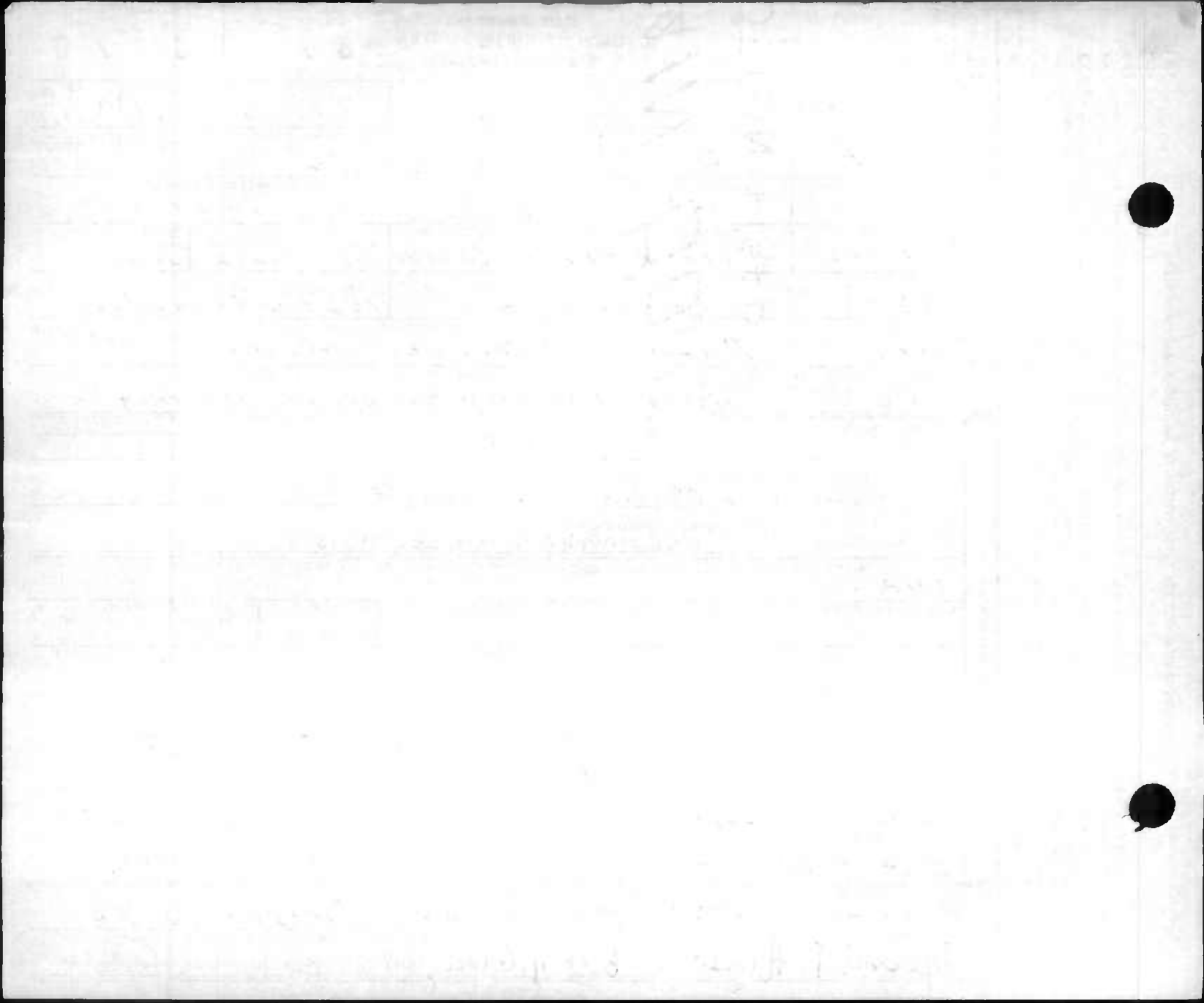
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 13478	
FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) DOROTHY FERGUSON					2a. DATE OF DEATH MONTH DAY YEAR 5-12-87					2b. HOUR 9:00 P	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 29 30		6. AGE (IN YEARS LAST BIRTHDAY) 56			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY at Home		
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1027 N CARROLLTON AVE			
14. FATHER'S NAME FIRST MIDDLE LAST PETER BROWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH MASON				16. ADDRESS ANNIE MAE BARNES Wagoner VA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 575-48-4522		17. INFORMANT ANNIE MAE BARNES Wagoner VA				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA - ATELECTASIS -			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA -											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 86 , to 5-12 , 19 87 , that (I) (we) lost saw the deceased alive on 5-12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bich T Duong					DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG					22e. ADDRESS LIBERTY MEDICAL CENTER						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5/14/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Meridian		23d. LOCATION CITY OR TOWN COUNTY STATE 50800 CV VA					
24. FUNERAL DIRECTOR NAME Marshall P. Hayes					ADDRESS 638 N. Gilman		25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

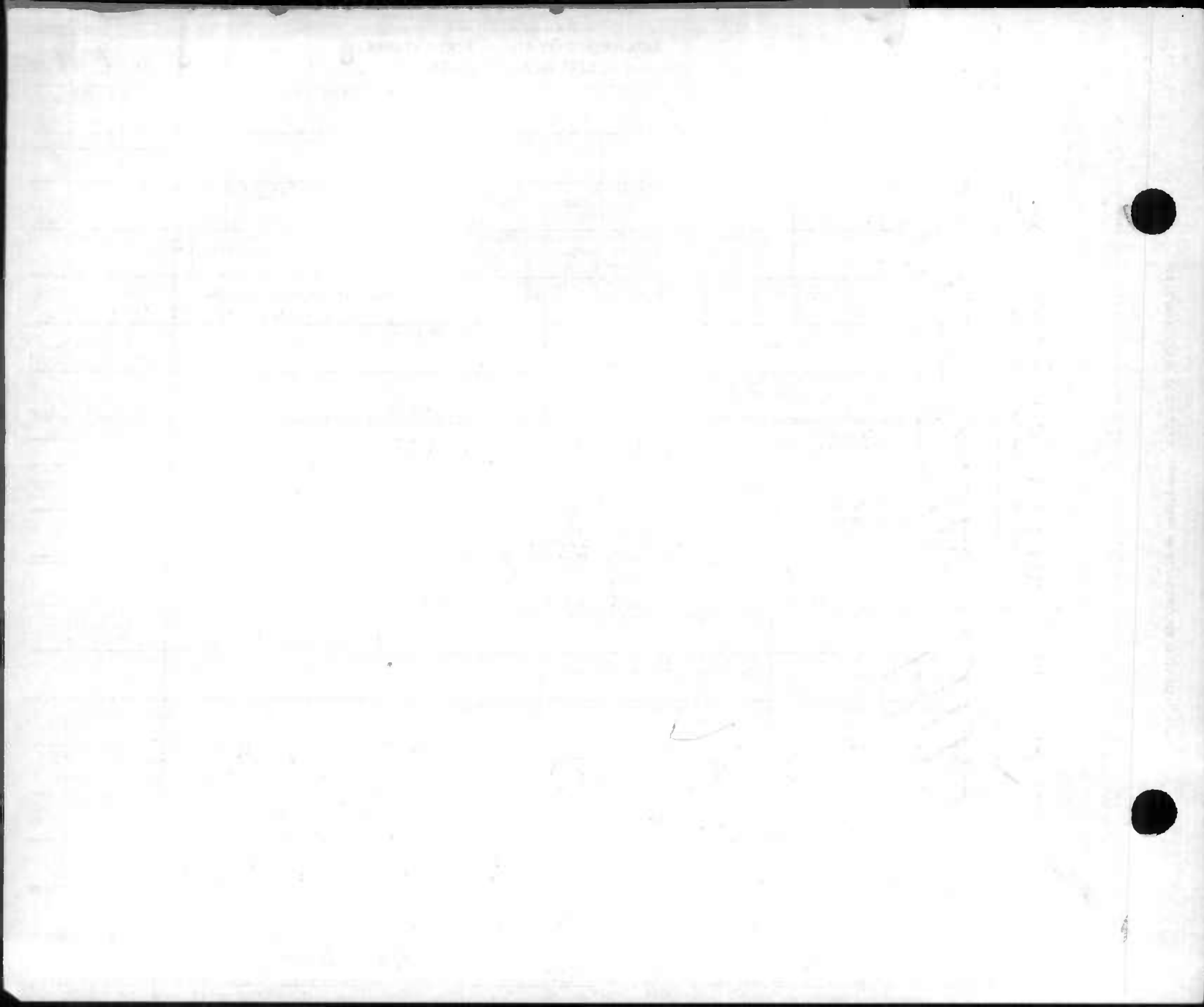
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William O. Ferguson		2a. DATE OF DEATH MONTH DAY YEAR 5 1 1987		2b. HOUR M	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 2 7 1924	
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		8. CITIZEN OF WHAT COUNTRY? U S A	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3227 Vickers Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 3227 Vickers Road 21216	
13b. STATE Md		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William O. Ferguson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxie Bowman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes	
16b. SOCIAL SECURITY NO. 224-22-7496		17. INFORMANT Selma F Hardy		ADDRESS 5135 7th St N. E. Wash D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>uremia - Chronic Renal Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>29 April 87</u> , 19 <u>87</u> , to <u>1 May 87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>29 April 87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Curtis E Davis</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CURTIS E DAVIS</u>		22e. ADDRESS <u>Bon Secours 21223</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/6/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet	
23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue			
25a. DATE REC'D. BY REGISTRAR MAY 5 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



53609 MAY 10 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13480

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE Delores LAST FERRARA			2a. DATE OF DEATH MONTH DAY YEAR MAY 12, 1987		2b. HOUR 1:07P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1919		6. AGE [IN YEARS (LAST BIRTHDAY)] 67 YRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Trovato		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Recuperio		13e. STREET ADDRESS / ZIP CODE 5956 Glenfalls Avenue 21206				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-4937		17. INFORMANT ADDRESS Mr. Anthony V. Ferrara, Sr. same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, electromechanical dissociation 8705 DUE TO, OR AS A CONSEQUENCE OF (b) Perforation of Left Iliac Artery DUE TO, OR AS A CONSEQUENCE OF (c) Manipulation of intravascular catheters during coronary angioplasty APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate immediate hours								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 8, 1987, to May 12, 1987, that (I) (we) last saw the deceased alive on May 12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE GARY D. WALFORD MD				DEGREE MD		22c. DATE SIGNED 5/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY D. WALFORD				22e. ADDRESS 502 Halted Bldg. Johns Hopkins Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/15/1987		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 15 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Lindner		

MEDICAL CERTIFICATION

27999

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED ON APPROVAL DR. ZANE PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move copies of this Form, page 2, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13481

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR Fine			2a. DATE OF DEATH MONTH DAY YEAR 5 23 87		2b. HOUR 7 P.M.	
3. SEX MALE		4. RACE XX CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 8, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESSER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH FINE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER GOLDBERG		13e. STREET ADDRESS / ZIP CODE 103 3rd AVE., S.E. (21061)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-30-0473		17. INFORMANT NAME ADDRESS ETLA JUNE FINE 103 3rd AVE. S.E. GLEN BURNIE MD. (21061)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PLEURAL EFFUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) DEEP VEIN THROMBOSIS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from MAY 18 19 87 to MAY 23 19 87 , that (I) (we) lost saw the deceased alive on MAY 23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Oscar C. Mendez, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 23 May '87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR C. MENDEZ, M.D.		22e. ADDRESS ST. AGNES HOSPITAL 900 CATO AVE. BALTIMORE, MD 21224				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/25 87		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS BALTO. MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Lila Gordon-Randall

MEDICAL CERTIFICATION

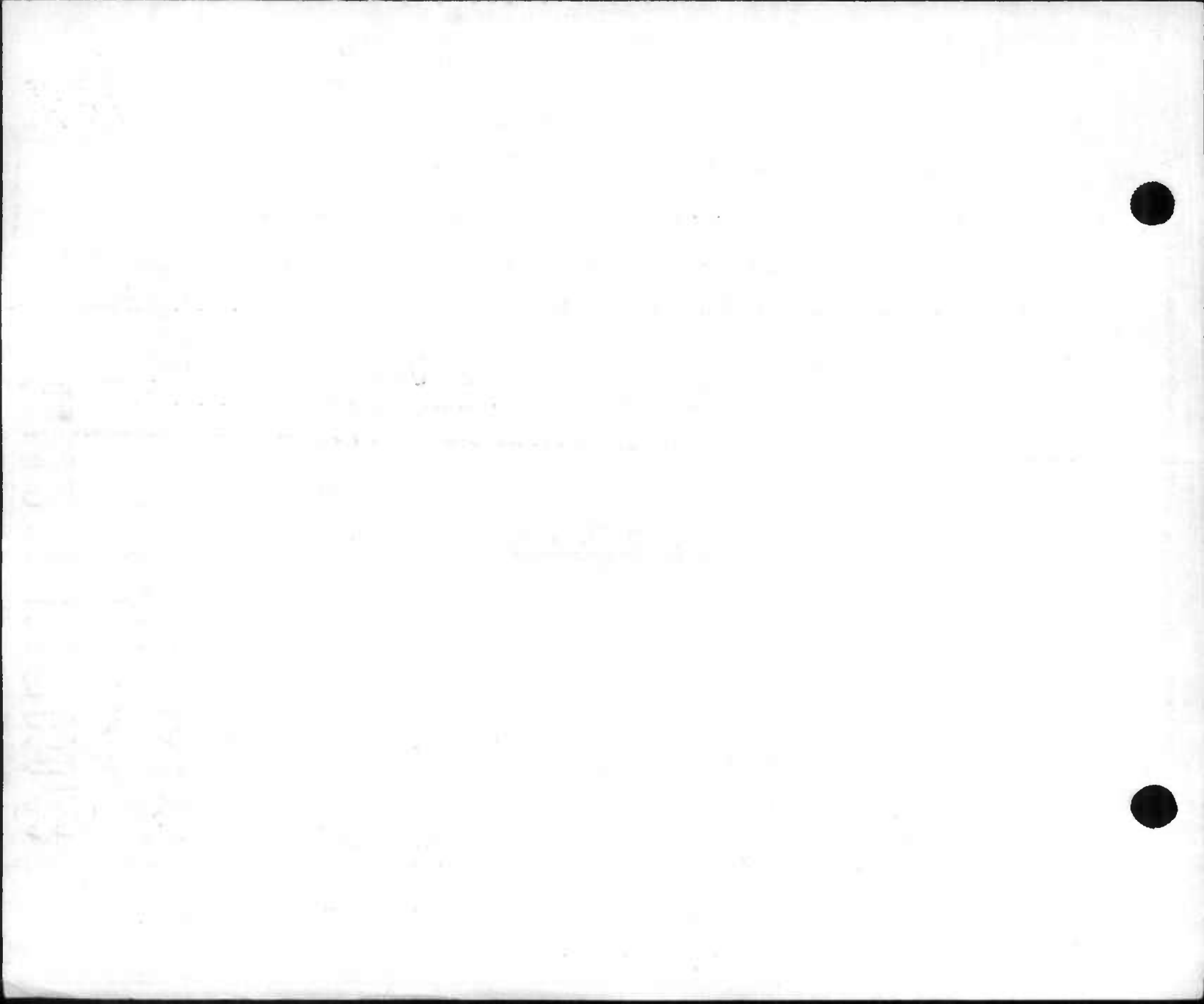
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 1 3 4 8 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada Elizabeth Finney				2a. DATE OF DEATH MONTH DAY YEAR May 26, 1987				2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 14 17		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) 2127 Callow Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2127 Callow Ave. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST IRA MILBOURNE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-20-6568		17. INFORMANT ADDRESS 8 Tamara Kidd 843 Lennox St. 21217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>86</u> , to <u>present</u> , 19 <u>87</u> , that (I) (we) lost above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Carl Sperling M.D.</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLING, M.D.				22e. ADDRESS 302 E. 33RD ST. Balto. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson</u>	

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Handwritten text, possibly a list or table, located at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

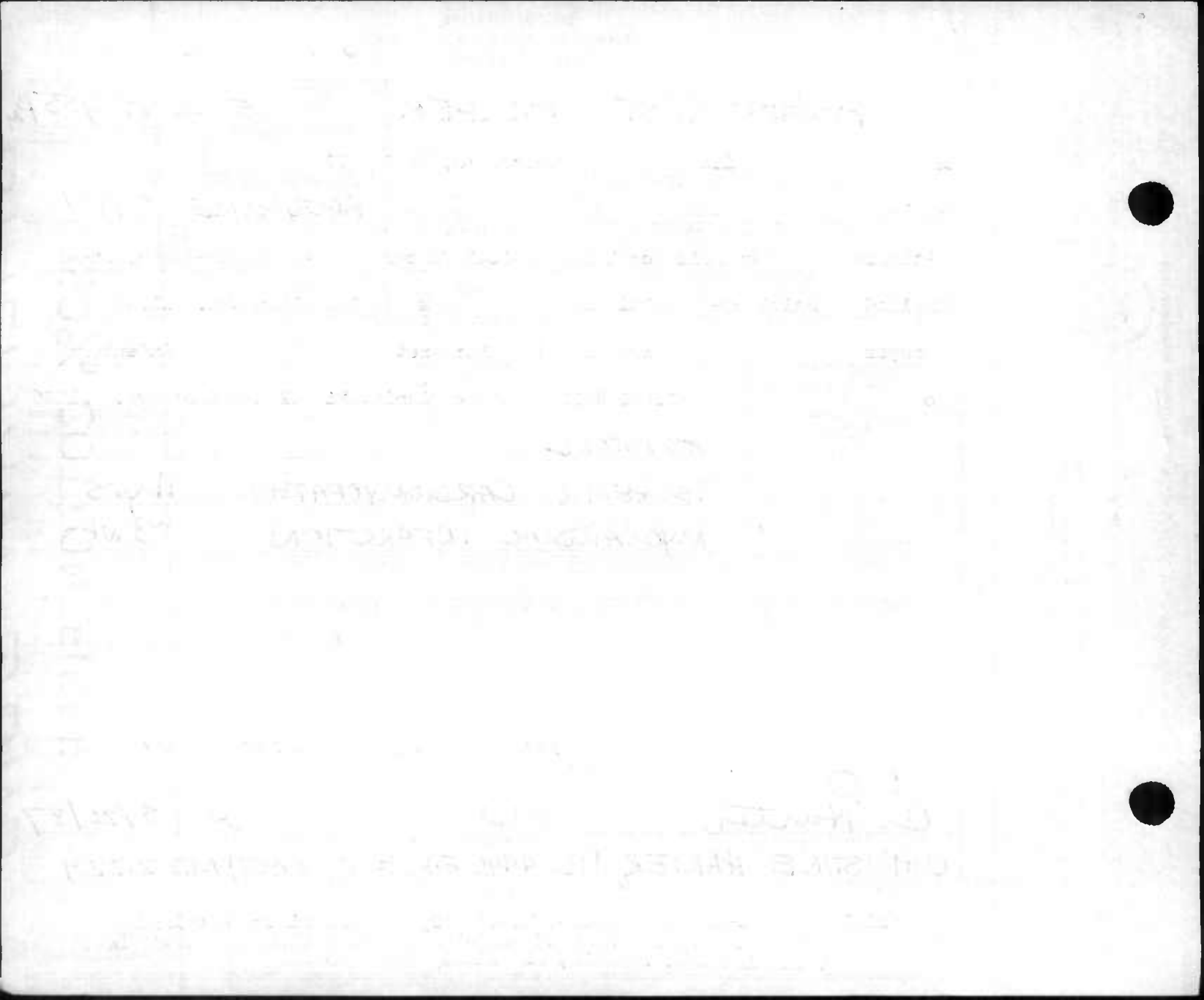
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 13483			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ernest J. Fischer				2a. DATE OF DEATH MONTH DAY YEAR 5 20 87 2b. HOUR 955 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 18, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Open Hearth--		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Casper Fischer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lindenberg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 213-03-4439		17. INFORMANT ADDRESS Helene Wisniewski 4242 Seidel Ave. 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASYSTOLE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ISCHEMIC CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs ~3 wks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>87</u> to <u>5/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.							
22b. SIGNATURE <u>C. Harter</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHRISTINE HARTER MD</u>				22e. ADDRESS <u>4940 EASTERN, BALT, MD 21224</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-25-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Ht of Mary</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck Funeral Home of Dundalk</u>		ADDRESS <u>7922 Wise Ave. Dundalk, MD 21222</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 25 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

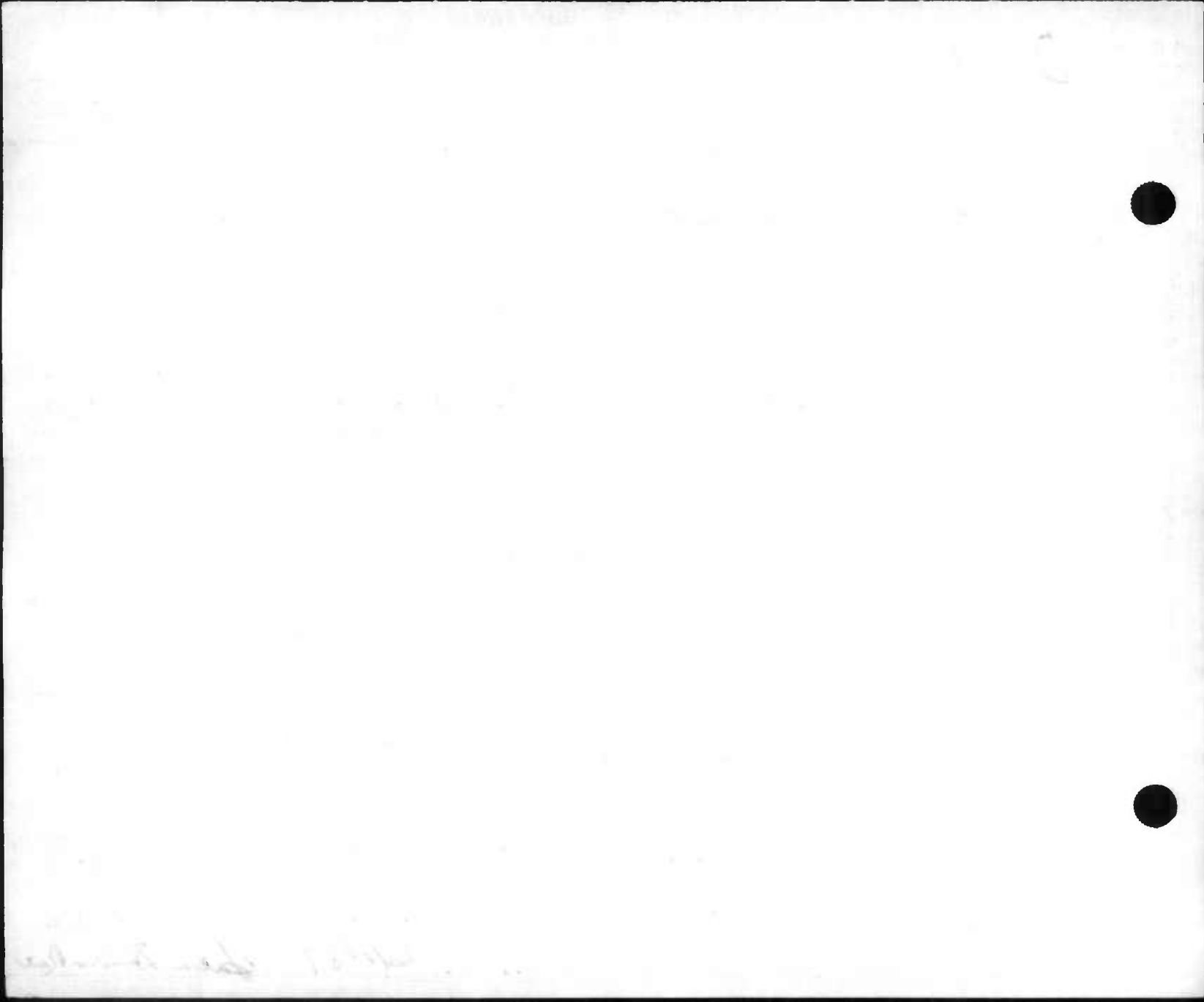
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DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 1 3 4 8 4

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
CHARLES FISHER			5 31 87			11:45 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	04 TH 13 13	74			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Smith	U. S. A.				Balto. City MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Balto.	Church Hosp.							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.						Balto.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS / ZIP CODE		
						501 W. Franklin 21201		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			065-30-7710			Sch. Nator 1/4 501 W. Franklin St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GI OBSTRUCTION								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GI BLEED, DEMENTIA								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			5/31 1987					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22a. I certify that (he) (this hospital) attended the deceased from 5/28, 1982, to 5/31, 1987, that (we) last saw the deceased alive on 5/31, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Paul Gormley			MD			5/31/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. CHURCH HOSPITAL CORPORATION		
PAUL GORMLEY, M.D.			100 N. BROADWAY			BALTIMORE, MD 21231		
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial Removal			5-31-87			Md. V.A. Burial		
23d. LOCATION			23e. COUNTY			23f. STATE		
Baltimore County			Md.			Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
State Anatomy Board Balto., Md.			6/1/87			John David R. Rader		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

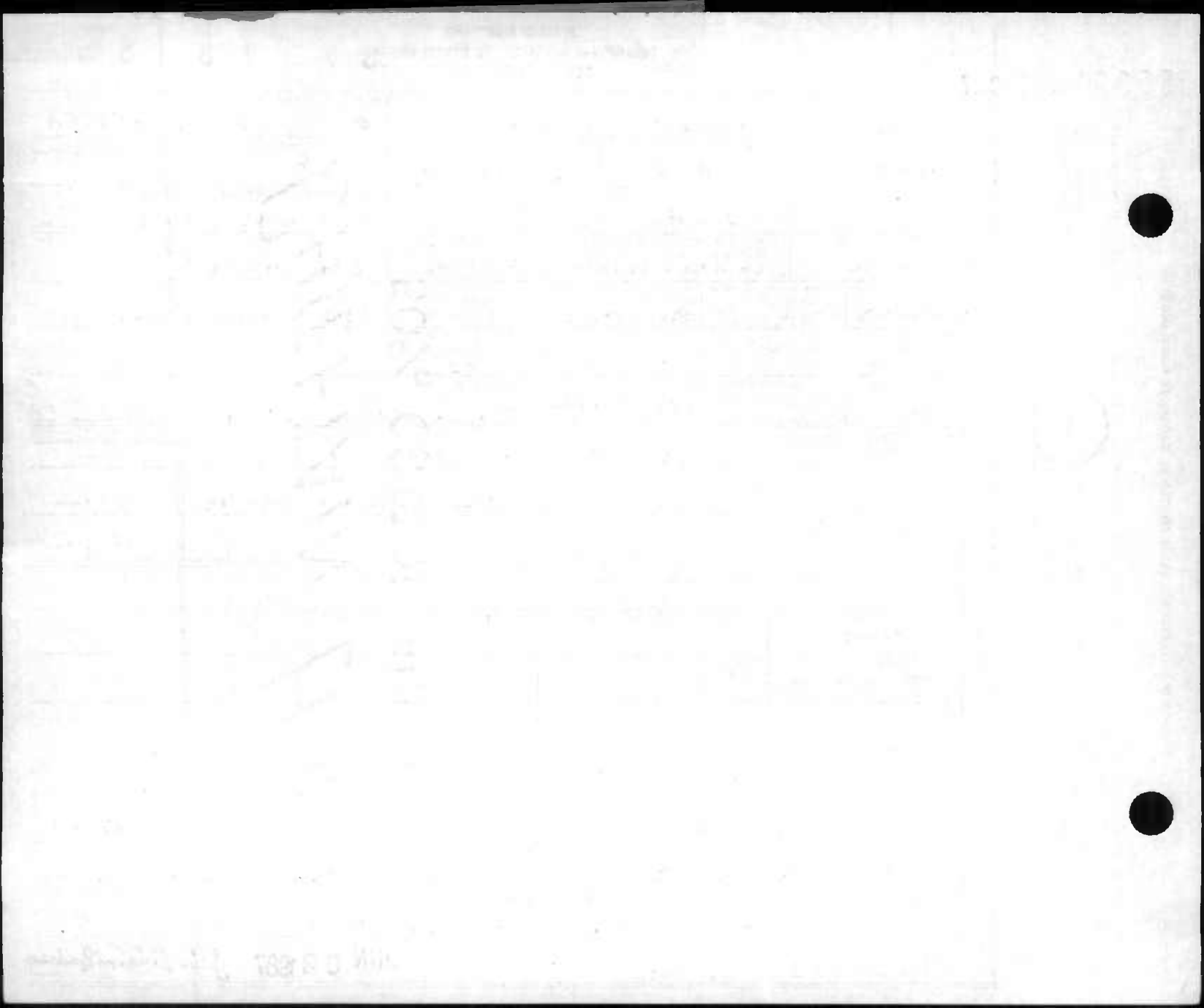
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DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLOYS HUBERT FLANARY			2a. DATE OF DEATH MONTH DAY YEAR 5 29 87		2b. HOUR 635 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 14 19	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCH RAVEN VETERANS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COAL MINER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY Carroll	13c. CITY OR TOWN HAMPSTEAD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Flanary		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lawson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW2	17. INFORMANT ADDRESS Mrs. E. Leona Flanary, Hampstead, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SMOKING</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 30 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-8-87</u> , 19 <u>87</u> , to <u>5-29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J L W Dunner MD				22c. DATE SIGNED 5-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS DUNNER MD				22e. ADDRESS LOCH RAVEN VETERANS HOSPITAL BALT. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Gamber Carroll Md.
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				25a. DATE REC'D. BY REGISTRAR JUN 02 1987	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

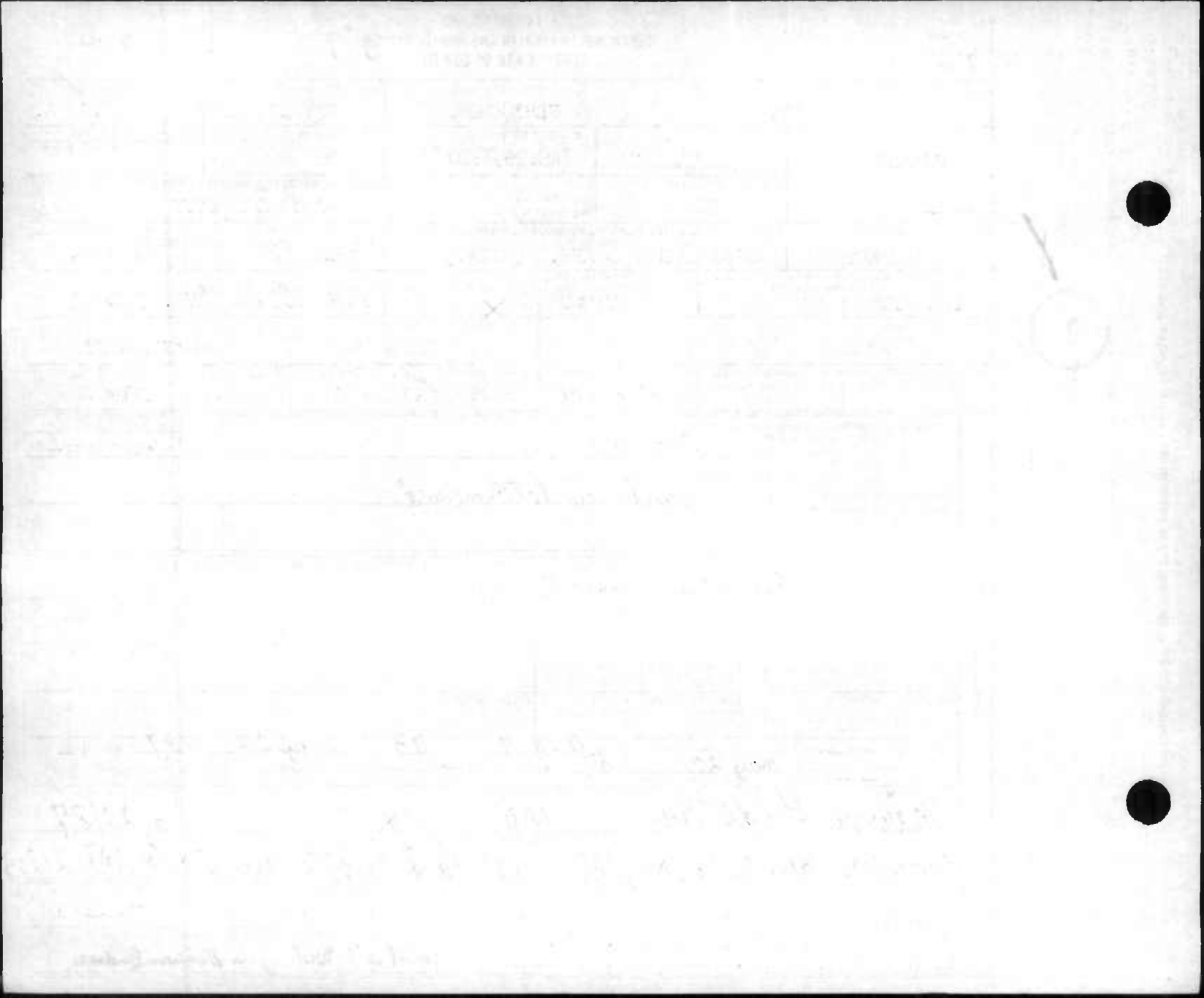
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SARA FLEISCHER			2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1987			2b. HOUR 7:45 A.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN. 29, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3406 OAKFIELD AVE. (21207)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3406 OAKFIELD AVE. (21207)	
14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL BUCKNER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA NEPORTOWSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-10-0776B		17. INFORMANT MR. HARRY FLEISCHER 3406 OAKFIELD AVE. BALTO., MD 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cause undetermined</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Aug. 7, 1987</u> to <u>May 22, 1987</u> that (I) <u>we</u> last saw the deceased alive on <u>May 20, 1987</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>have</u> <u>not</u> (did not) view the body after death.									
22b. SIGNATURE <u>Marvin Goldstein</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/22/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN GOLDSTEIN, MD					22e. ADDRESS 6001 Park Heights Ave. Balto., MD 21215				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 24, 1987		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD 21215					25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudolph</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

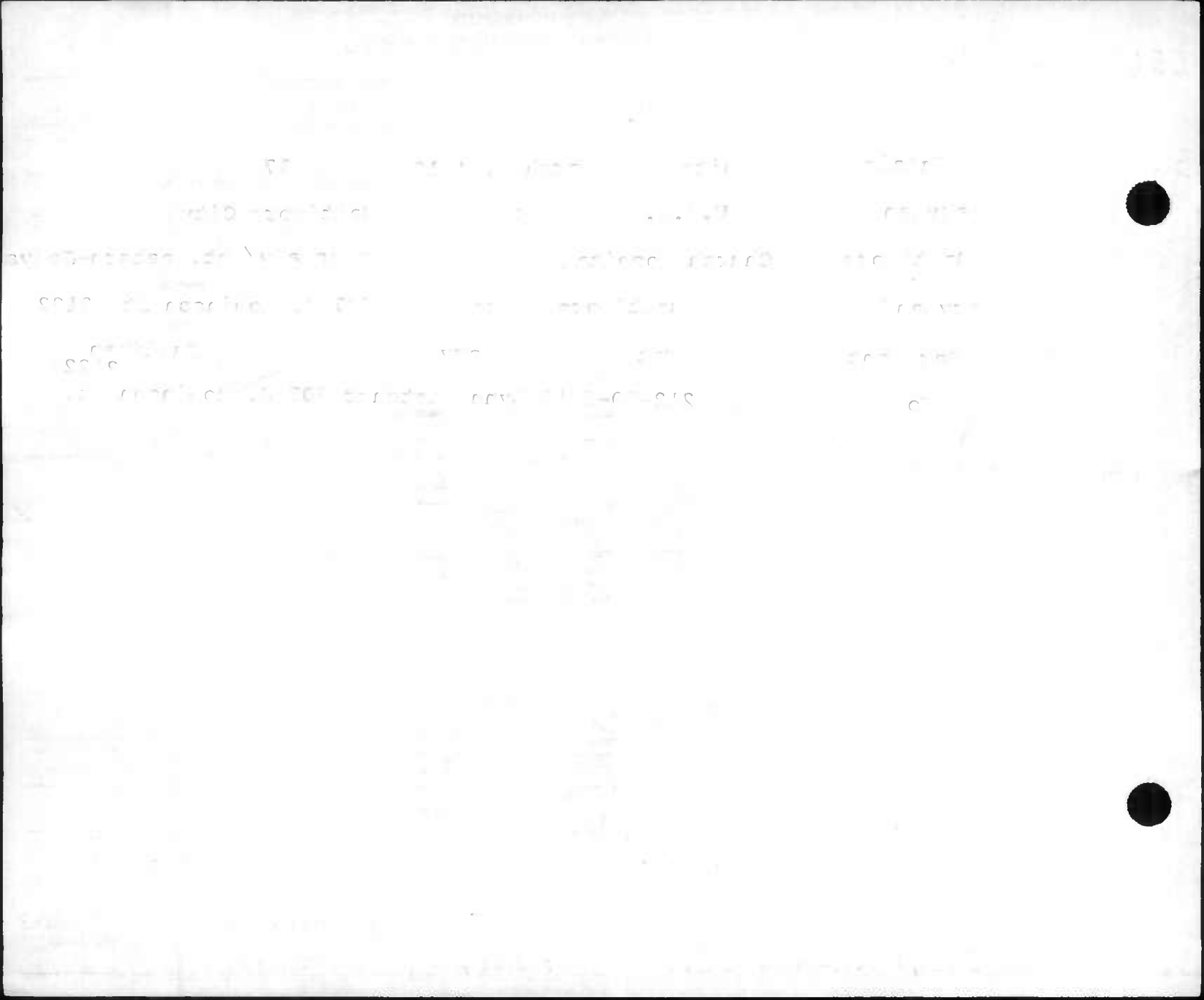
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 8 7

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MARGARET F. FLETCHER		2a. DATE OF DEATH MONTH DAY YEAR MAY 18 1987		2b. HOUR 9:25pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady/Ret.		12b. KIND OF BUSINESS OR INDUSTRY Eastern-Jadys			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 607 S. Robinson St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Sargeant Tate		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sullivan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-30-5513		17. INFORMANT ADDRESS Lynn Fletcher 607 S. Robinson St. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 7 19 87, to MAY 18 19 87, that (I) (we) lost saw the deceased alive on MAY 18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Beena Nagpal		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beena Nagpal, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE MD. 21231							
23a. BURIAL (SPECIFY) CREMATION		23b. DATE 5-21-87		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Joseph N. ZANNINO JR.		ADDRESS 263 S. CONKLING ST. 21224		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13488

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Homer Edward FLIPPO		May 19, 1987		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		August 2, 1931		55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A.				Baltimore City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		230 S. Broadway 21231		Labor		Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Robert T. Flippo		Irma Estelle Mitchell		Yes		214-26-9495	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Michael Krystofiak		230 S. Broadway 21231					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/10/83, 19 to 3/18/87, 19 that (1) (we) last saw the deceased alive on 3/18/87, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		[Signature]		May 22, 1987		Alan Perez, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		May 22, 87		Garrison V.A. Cem.		Garrison, Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Dippel Funeral Homes, Inc.		7110 Belair Road Baltimore, Maryland 21206		MAY 21 1987		[Signature]	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Previous CVA's; Intermittent claudication

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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COLLO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13489

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Moses			M,	Flood	5	29	87		3 ²⁰ PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	BLACK	MONTH DAY YEAR 6 3 22		64		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NC.	USA			Baltimore City, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Union Memorial Hospital								
13a. STATE					13b. COUNTY				
MD					BALTO.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST MARCELLUS C FLOOD					FIRST MIDDLE LAST GRACIE LEE HAWKINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NAVY		WHIT		23922-4603		CAROL/No/c		19036 E. 30 th ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uncal Herniation</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Edema</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
<u>Seizure Disorder, Previous CVA, COPD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>87</u> , to <u>5/29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
<u>Scm</u>		MD						5/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
T. C. Trogesser, M.D.				Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
		6/1/87		EASTVIEW Cem.		BALTO.		MD.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Betty's Funeral Home				129 N. Calver St.		JUN 2 1987		<u>John T. Trogesser</u>	

BP

2025 COTTON FINE

53585 MAY 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13490

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD Jerome FLYNN Jr.			2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1987		2b. HOUR 4:30 ^P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 11 1927		
6. AGE (IN YEARS LAST BIRTHDAY) 60		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Seaman		
14. FATHER'S NAME FIRST MIDDLE LAST Howard Jerome Flynn Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Julia Skirka		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) Yes Korean		
16b. SOCIAL SECURITY NO. 220-18-2813		17. INFORMANT Thomas W. Sands		ADDRESS 3521 E. Baltimore St. 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from MAY 09 1987 to MAY 11 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED 5/11/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles S. Zeiler & Son Inc.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. X8888X		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		
23d. LOCATION CITY OR TOWN COUNTY STATE Garrison, Balto. Co., Md. 21231		24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		25a. DATE REC'D. BY REGISTRAR MAY 14 1987		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 4 9 1

REG. NO.

1. FOR
STATE
REGISTER

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL T. FOOSE			2a. DATE OF DEATH MONTH DAY YEAR 5 26 87		2b. HOUR 2 45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 19 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA		13b. COUNTY YORK	13c. CITY OR TOWN YORK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George MARTIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA GREBBING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 178-16-0036		17. INFORMANT ADDRESS RICHARD M. FOOSE JR. 126 AYLESBURY RD. TIMMONSVILLE	

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-11-87 to 5-26-87 , that (I) (we) last saw the deceased alive on 5-26-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.			
22b. SIGNATURE Carla A. Alexander		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5-26-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carla Alexander, M.D.		22e. ADDRESS Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204	

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE MAY 29, 1987	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALTIMORE, MARYLAND
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24. FUNERAL DIRECTOR
(NAME ADDRESS)
BAUMEISTER & ORCUTT MORTUARY INC. 751 S. Queen Street York, PA

25. DATE REC'D. BY REGISTRAR
JUN 02 1987

26. REGISTRAR'S SIGNATURE
James R. Davidson-Randall

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advice obtained.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13492

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carlton Cecil Fore			2a. DATE OF DEATH MONTH DAY YEAR May 05-20-87		2b. HOUR 2:20 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 1, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman (Ret)	12b. KIND OF BUSINESS OR INDUSTRY MTA	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Anne Arundel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1316 Aster Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Fore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice E. Mayberry		ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Wife) Luella N. Fore		Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus, Peripheral Vascular Disease,</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>5-14</u> 19 <u>87</u> , to <u>5-20</u> 19 <u>87</u> , that (we) lost above, (s) (we) (did not) view the body after death.					
22b. SIGNATURE <u>AMAEEFULE</u>				22c. DATE SIGNED 05/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMAEEFULE				22e. ADDRESS SBCG H. 3001 S. Hanover St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
23d. LOCATION CITY OR TOWN Elkridge		23e. COUNTY Howard		23f. STATE Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				25a. DATE REC'D. BY REGISTRAR MAY 26 1987	
ADDRESS Glen Burnie, Maryland				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA E. FOREMAN			2a. DATE OF DEATH MONTH DAY YEAR MAY 23, 1987		2b. HOUR 6:40A M
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 9 18 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY	13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3531 Reisterstown Road 21215		
14. FATHER'S NAME FIRST MIDDLE LAST John Carter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Harcum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-40-7300		17. INFORMANT ADDRESS S. Marie Fortson 3115 Virginia Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL FAILURE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u> <u>1 WEEK</u> <u>3 YEARS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> 19 <u>87</u> to <u>5/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Sydney S. Moon</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/23</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SYDNEY S. MOON</u>		22e. ADDRESS <u>6000 N. WOLF ST</u> <u>JOHNS HOPKINS</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue			25a. DATE REC'D. BY REGISTRAR JUN 1 1987		
			25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Kendall</u>		

054779 MAY 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

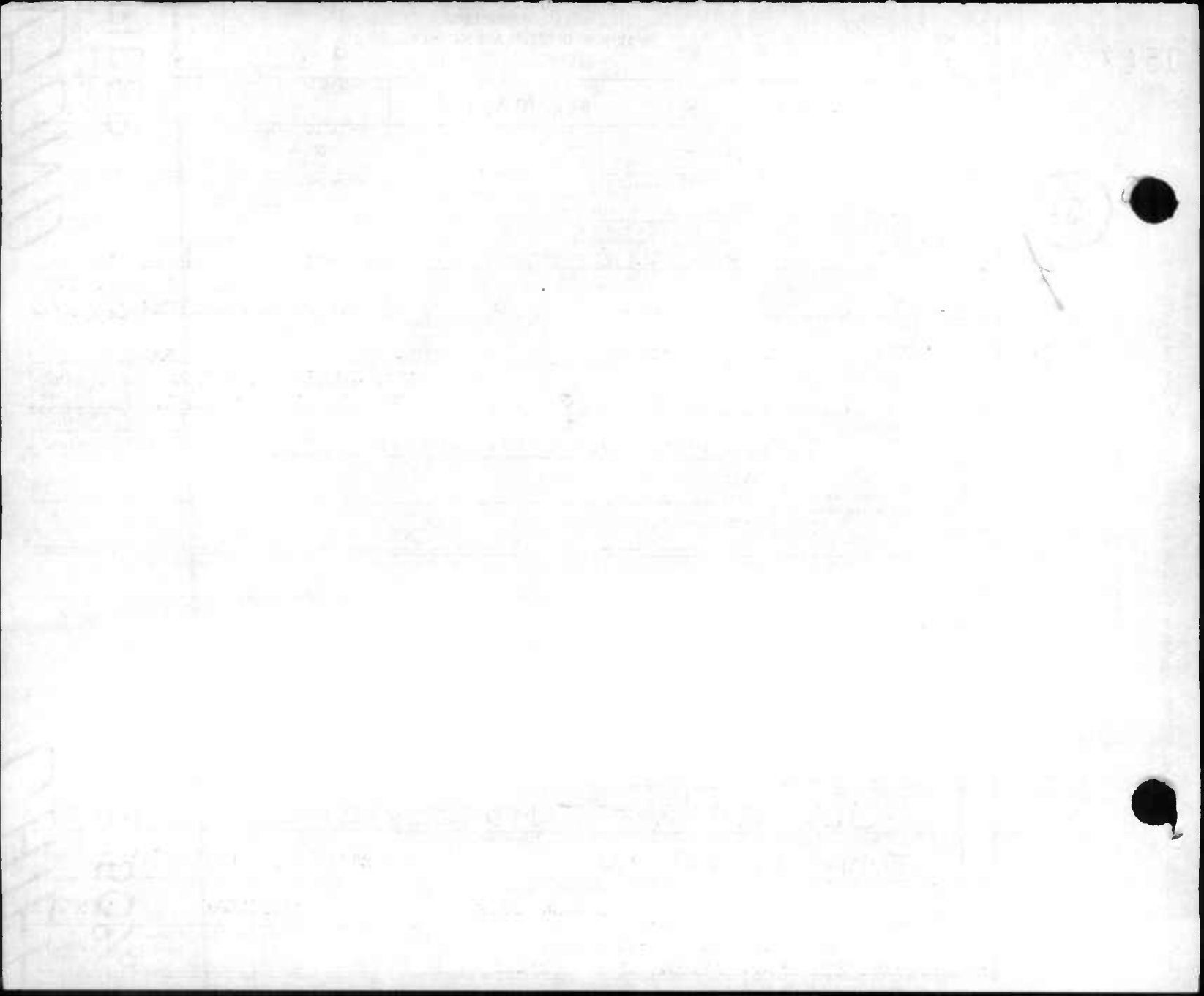
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 13494 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS R FORMAN					2a. DATE OF DEATH MONTH DAY YEAR 5 21 87			2b. HOUR 5:15 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 19 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEM. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY AT LAW	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTO.		13e. STREET ADDRESS / ZIP CODE APT. 409 116 W. UNIVERSITY PKWY 21210			
14. FATHER'S NAME FIRST MIDDLE LAST DAVID L. FORMAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL SHAPIRO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-38-5160		17. INFORMANT ADDRESS MRS. LILLIAN W. FORMAN APT. 409 116 W. UNIVERSITY PARKWAY BALTO., MD 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/21, 19 87, to 5/21, 19 87, that (I) (we) last saw the deceased alive on 5/21, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John M. Wogan				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. WOGAN				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 22, 1987		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson			

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

13495

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. HOUR
William Ronald Forsyth					DATE KNOWN OF DEATH	MONTH DAY YEAR	2b. HOUR
					<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	5 9 19 87	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	Sept 17, 1959	27 YRS.	MONTHS	DAYS	5 9 19 87	6AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md	U.S.A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	University Hospital (STU)	Carpenter		Building			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.	Carroll	Sykesville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7609 Mellor Ave			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Robert H. Forsyth SR.		Doris Audrey Dixon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Audrey Forsyth - Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Shogtun wound of left thigh							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		0:50 M. 5 8 19 87		Subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
		home		7609 Mellor Ave, Sykesville, Carroll, MD.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
Margarita A. Korell		Assistant				5/9/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Margarita A. Korell, M.D.		111 Penn St. Balto.MD.					
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial	5-12-87	Springfield Cemetery		Sykesville Carroll Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry W. Haight		Sykesville, Md.		MAY 12 1987		Lelia Davidson	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		REG. NO.			
1- Bernadine (aka Bernice Jenkins) Foshee		5/15/87		9-34 AM					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH					
Female	Caucasian	Sept. 24, 1928	58 YRS.	Baltimore City, MD.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.		Baltimore City, MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	Church Hospital Corporation	Laborer		Tailoring					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	203 S. Chester St. #21231					
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Alexander (aka Kane) Sokolowski	Anna Nietubioz	No		220-24-3401		Prince Frederick, Md. 20678			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST		18b. SOCIAL SECURITY NO.		17. INFORMANT		John D. Foshee-Box 211-Rte. 2 Mallard Pt. Rd.			
DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION		18b. SOCIAL SECURITY NO.		17. INFORMANT		John D. Foshee-Box 211-Rte. 2 Mallard Pt. Rd.			
DUE TO, OR AS A CONSEQUENCE OF		18b. SOCIAL SECURITY NO.		17. INFORMANT		John D. Foshee-Box 211-Rte. 2 Mallard Pt. Rd.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERIPHERAL VASCULAR DISEASE		18b. SOCIAL SECURITY NO.		17. INFORMANT		John D. Foshee-Box 211-Rte. 2 Mallard Pt. Rd.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (CITY OR TOWN STREET COUNTY STATE)							
22a. I certify that (this hospital) attended the deceased from May 15, 1987, to May 15, 1987, that (we) last saw the deceased alive on May 15, 1987, and that in our opinion death occurred on the date and hour and from the causes stated above (we) did not view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
		Y. K. SHETTY, M.D.		5/15/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN COUNTY STATE)					
Burial	5/18/87	St. Stanislaus Cem.	Baltimore City, Maryland						
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George A. Weber & Sons Inc.-705 S. Ann St.		MAY 18 1987		Baltimore-Randall					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

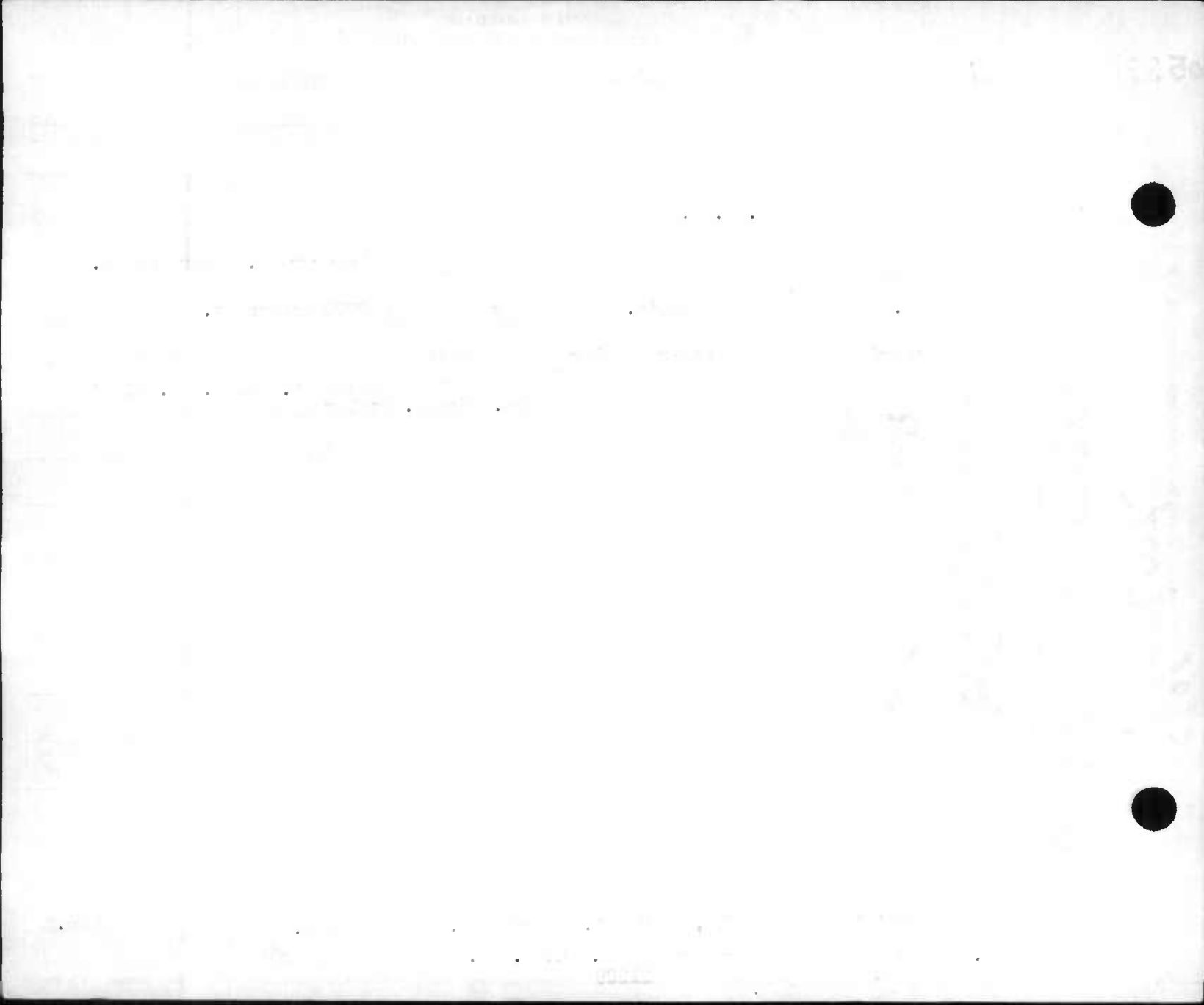
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Wilbur Fowler		2a. DATE OF DEATH MONTH DAY YEAR 5 8 87		2b. HOUR 1000PM 2300PM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 6 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer Md. Paper Box Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Fowler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Fogle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT 2208 Ashton St. Balto. Md. 21223 Mrs. Edna P. Fowler	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-25-87 to 5-8-87, 1987, that (I) (we) last saw the deceased alive on 5-8-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Katherine Tkaczuk		DEGREE MD		22c. DATE SIGNED 5-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE TKACZUK		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
23d. LOCATION CITY OR TOWN Balto.		23e. COUNTY Baltimore		23f. STATE MD	
24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md. 21229		25a. DATE REC'D. BY REGISTRAR MAY 12 1987			
25b. REGISTRAR'S SIGNATURE					



054547 MAY 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VIA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

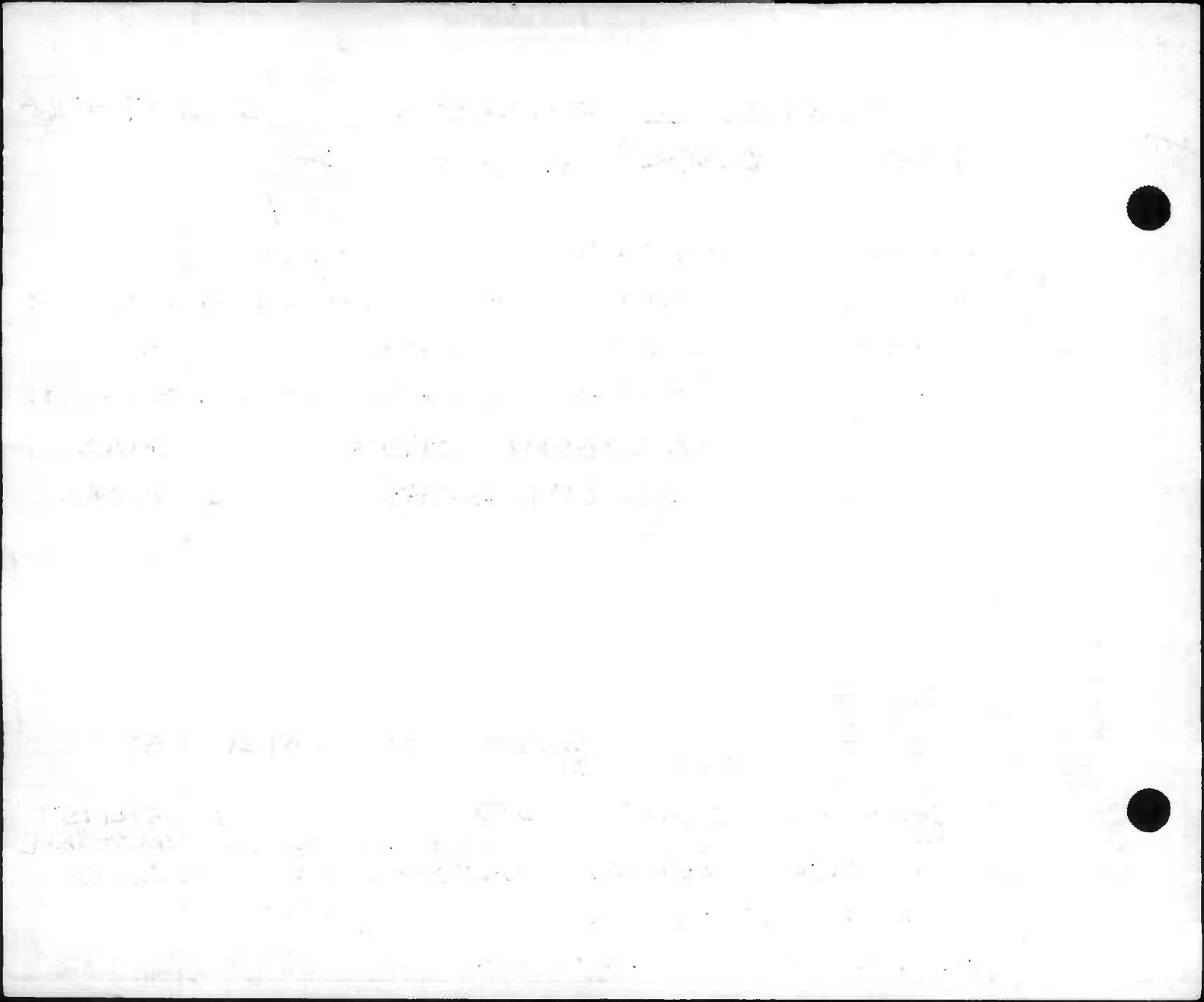
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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WENDELL L FOWLKES, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 5 21 87		2b. HOUR 4:26 AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 13 50		6. AGE (IN YEARS LAST BIRTHDAY) 36	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Marshall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Fowlkes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 219-52-8984		17. INFORMANT ADDRESS Dorothy Fowlkes 2040 E. Preston St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 20 19 87 to MAY 21 19 87 , that (I) (we) last saw the deceased alive on MAY 21 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jonathan A. Arens		DEGREE MD		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN ARENS		22e. ADDRESS MERCY HOSPITAL 301ST PAUL BALTIMORE MD 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/27/87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN Owings Mills MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR MAY 26 1987		25b. REGISTRAR'S SIGNATURE Julia Friedman-Rudner



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MAY 14

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) ARTHUR NATHANIEL FRAIDIN			2a. DATE OF DEATH MAY 6, 1987			2b. HOUR 10:20 P.M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH FEBRUARY 2, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LONG GREEN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FINANCIER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE (21218) 1 E. UNIVERSITY PKWY, APT. 311	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB FRAIDIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-22-7771A		17. INFORMANT CORINNE FRAIDIN			ADDRESS APT. 311 1 E. UNIVERSITY PKWY 21218		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Somewhat</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Alcoholism chronic. Hx of recurrent C.C.F.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 25, 19 86</u> to <u>MAY 6, 19 87</u> , that (I) (we) lost saw the deceased alive on <u>APR 29, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/7/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWIN S. BERTON</u>				22e. ADDRESS <u>302 E 33rd St BALTO 21215</u>					
23a. BURIAL, CREMATION, REMOVAL (S) <u>MAX BURIAL</u>		23b. DATE <u>5/8/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP CEM</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO</u>			
24. FUNERAL DIRECTOR NAME <u>SOL K. LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD. BALTO, MD 21215</u>				25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <u>MAY 13 1987</u> <u>[Signature]</u>					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with #72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

1000

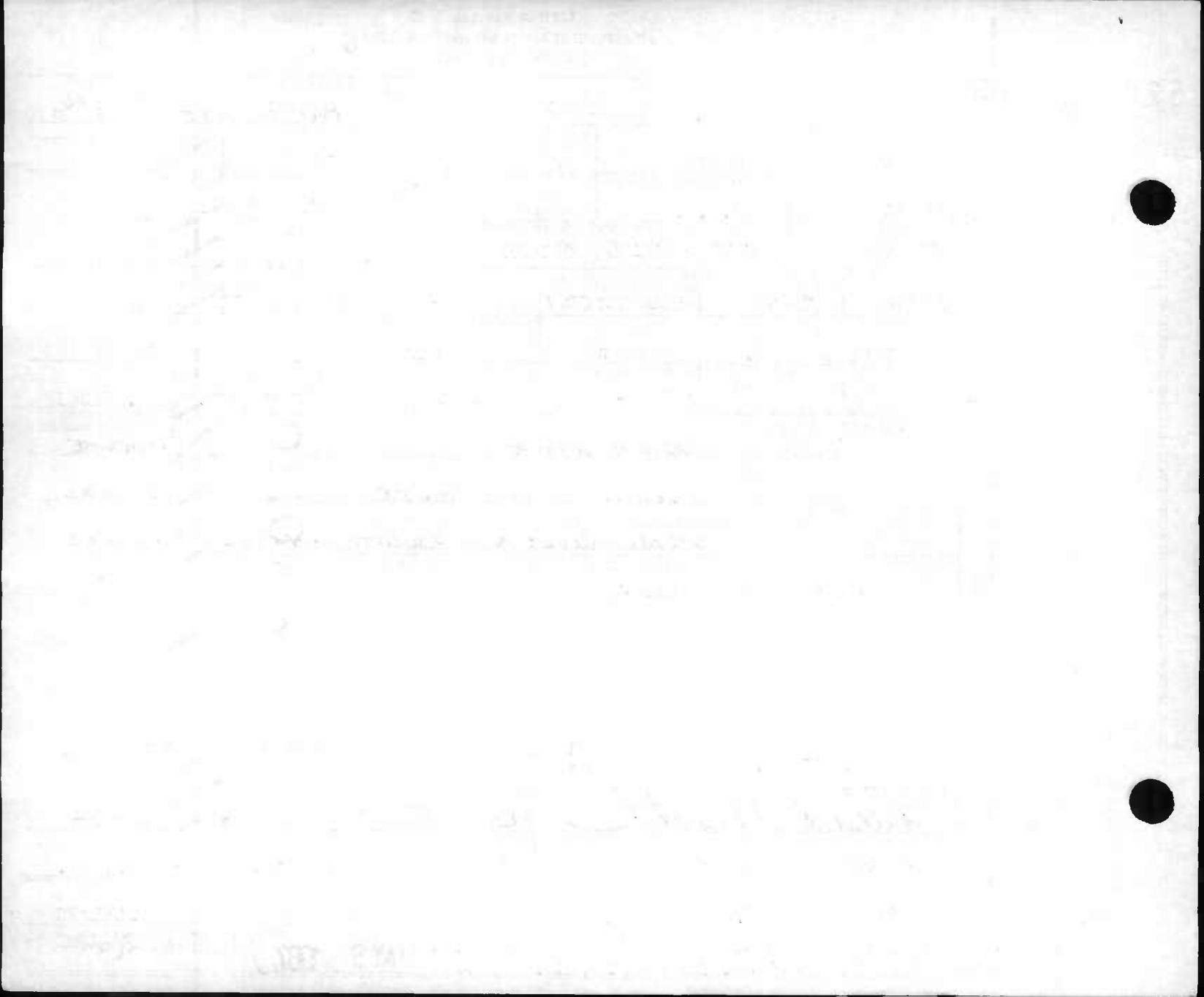
[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "1000" and "1000" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 1 3 5 0 0				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
EMMA M. FRANCE					MONTH 5 DAY 7 YEAR 87				
3. SEX FEMALE					2b. HOUR 7 26 P.M.				
4. RACE WHITE					6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.				
5. DATE OF BIRTH NOVEMBER 13, 1911					7. IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					8. IF UNDER 24 HRS. HOURS MIN.				
11. CITIZEN OF WHAT COUNTRY? U.S.A.					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL					12b. KIND OF BUSINESS OR INDUSTRY WHOLESALE				
13a. STATE MARYLAND					13b. STREET ADDRESS / ZIP CODE 9548 JOEY DRIVE 21043				
13c. CITY OR TOWN ELICOTT CITY					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. FRANCE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ECKELS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 213-10-7935				
17. INFORMANT DOUG FRANCE					ADDRESS 9548 JOEY DRIVE ELICOTT CITY, MD. 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE ORGAN FAILURE</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>SACRAL ULCER AND PERITONEAL ABSCESS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>DEPRESSION - MAJOR</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE									
2 WEEKS									
2 WEEKS									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 21</u> , 19 <u>87</u> , to <u>MAY 7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>MAY 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard P. Franklin</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22c. DATE SIGNED <u>5/7/87</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. FRANKLIN M.D.									
22e. ADDRESS UNION MEMORIAL HOSPITAL Baltimore, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL									
23b. DATE 5/11/87									
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK									
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND									
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228									
25a. DATE REC'D. BY REGISTRAR 7b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

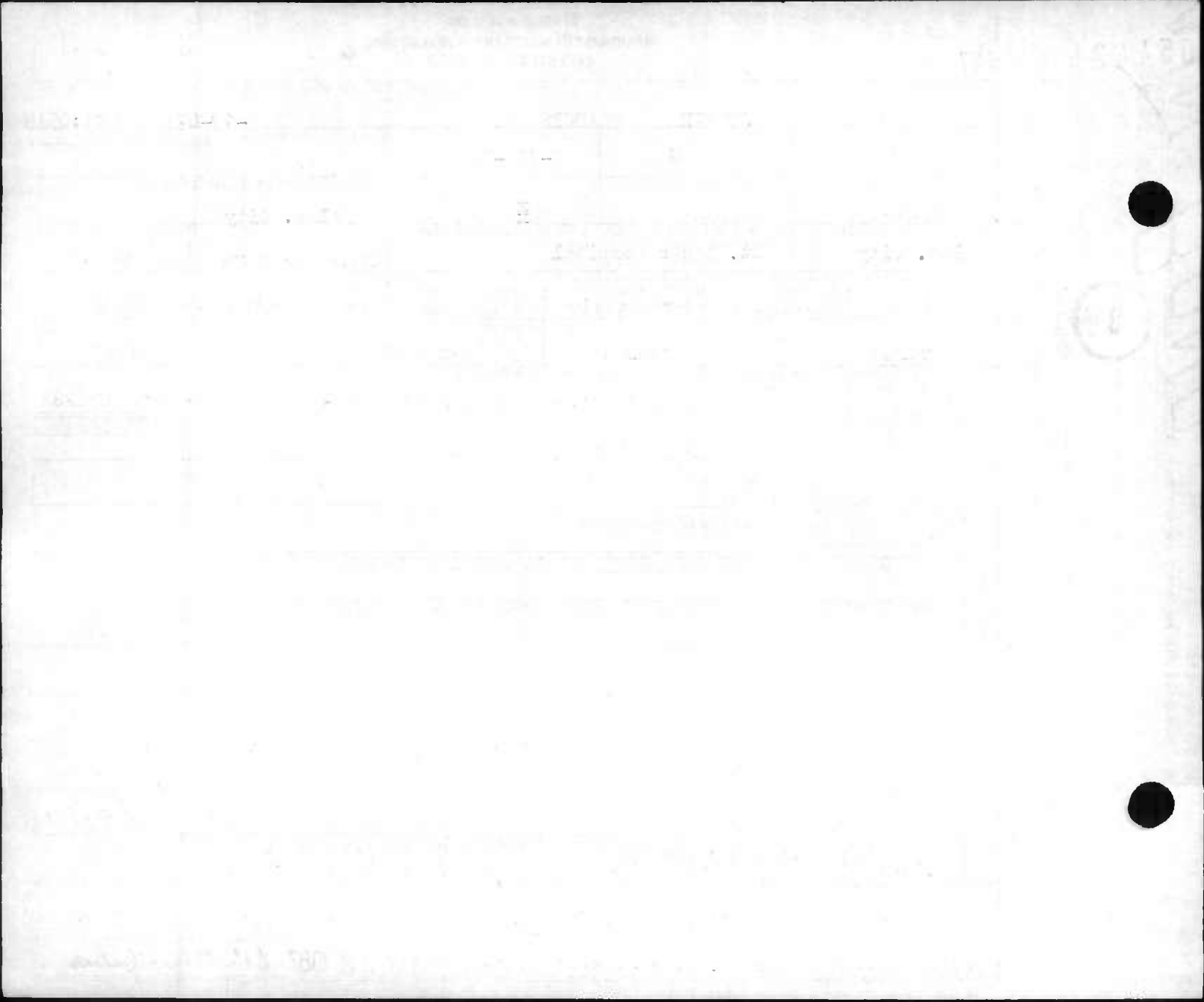
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 0 1

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
BERNARD JOSEPH FRANCIS, Sr.		5-19-87		11:05AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M	W	2-13-24	63	YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Balto. City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Balto. City	St. Agnes Hospital	Crane Operator	Koppers Co.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE
Maryland	Baltimore	Catonsville			418 Lafayette Ave. 21228
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
George Francis		Margaret Reilly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		217-16-6178	Patricia Freeman 418 Lafayette Ave. 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> 19 <u>87</u> to <u>5/19</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alvin Madarang</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALVIN MADARANG</u>		22e. ADDRESS <u>900 Caton Ave Balt. Md. 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/23/87	Cedar Hill Cemetery	Glen Burnie A.A. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc.		MAY 22 1987		<u>John R. Anderson-Randall</u>	



055453 JUN - 1987

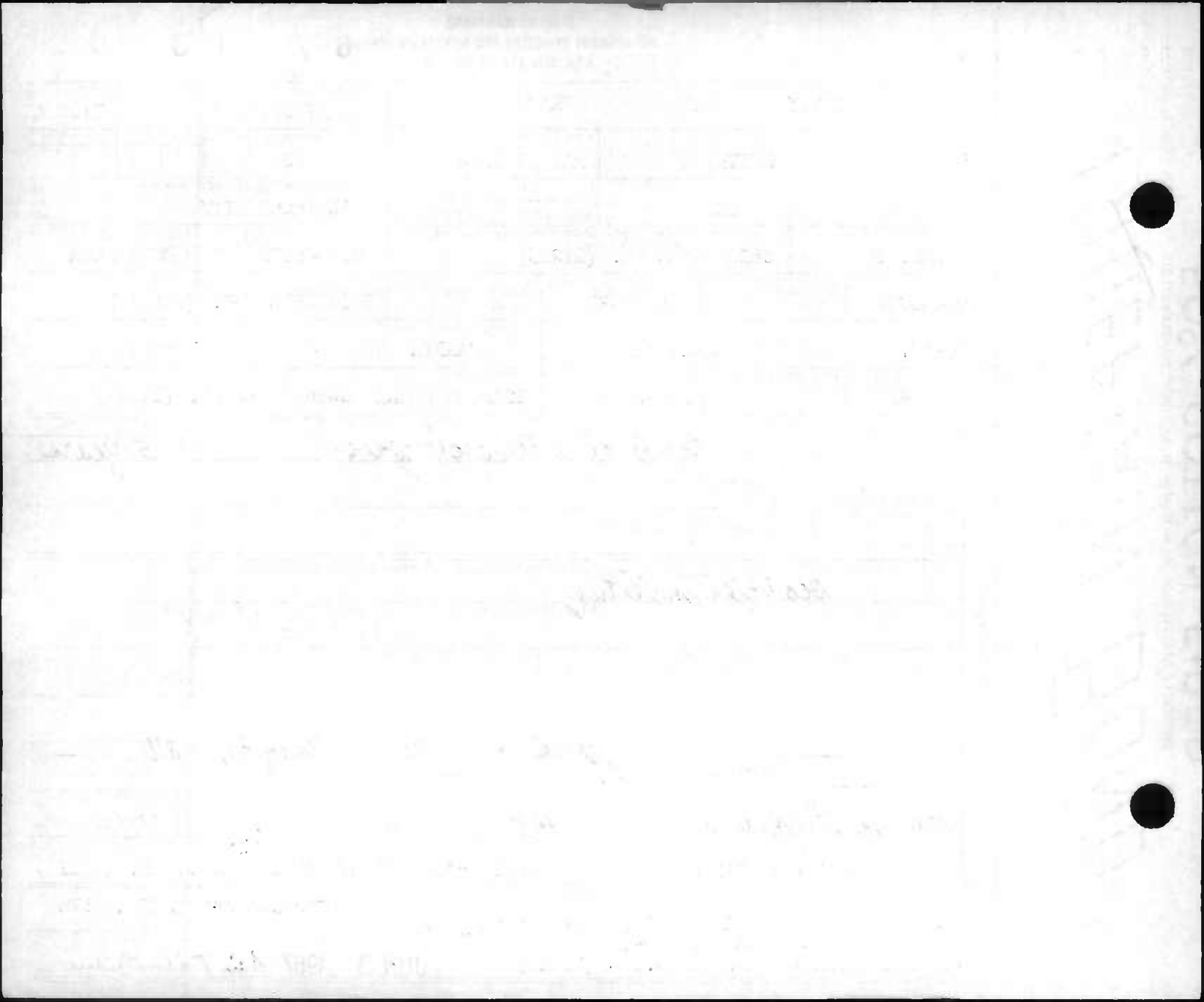
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 1 3 5 0 2			
FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST BETTY		MIDDLE LEE		LAST FRANK			2a. DATE OF DEATH MONTH DAY YEAR MAY 31, 1987		2b. HOUR 7:20 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 23, 1904			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3826 MENLO DR. (21215)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3826 MENLO DR. (21215)				
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL SHERMAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE KUHN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-22-4380			17. INFORMANT ADDRESS ISADORE FRANK 3826 MENLO DR. (21215)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>diabetes mellitus</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from <i>April 14, 1971</i> to <i>May 31, 1987</i> , that (I) lost saw the deceased alive on <i>May 6, 1987</i> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) was <i>did not</i> view the body after death.													
22b. SIGNATURE <i>Marvin Goldstein</i>						DEGREE MD			22c. DATE SIGNED 6/1/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN GOLDSTEIN						22e. ADDRESS 6001 PARK HEIGHTS AVE. BALTO., MD. (21215)							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 1, 1987		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK			23d. LOCATION RANDALLSTOWN, BALTO., MD.					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD (21215)						25a. DATE REC'D. BY REGISTRAR JUN 3 1987		25b. REGISTRAR'S SIGNATURE <i>Leia Davidson-Randall</i>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

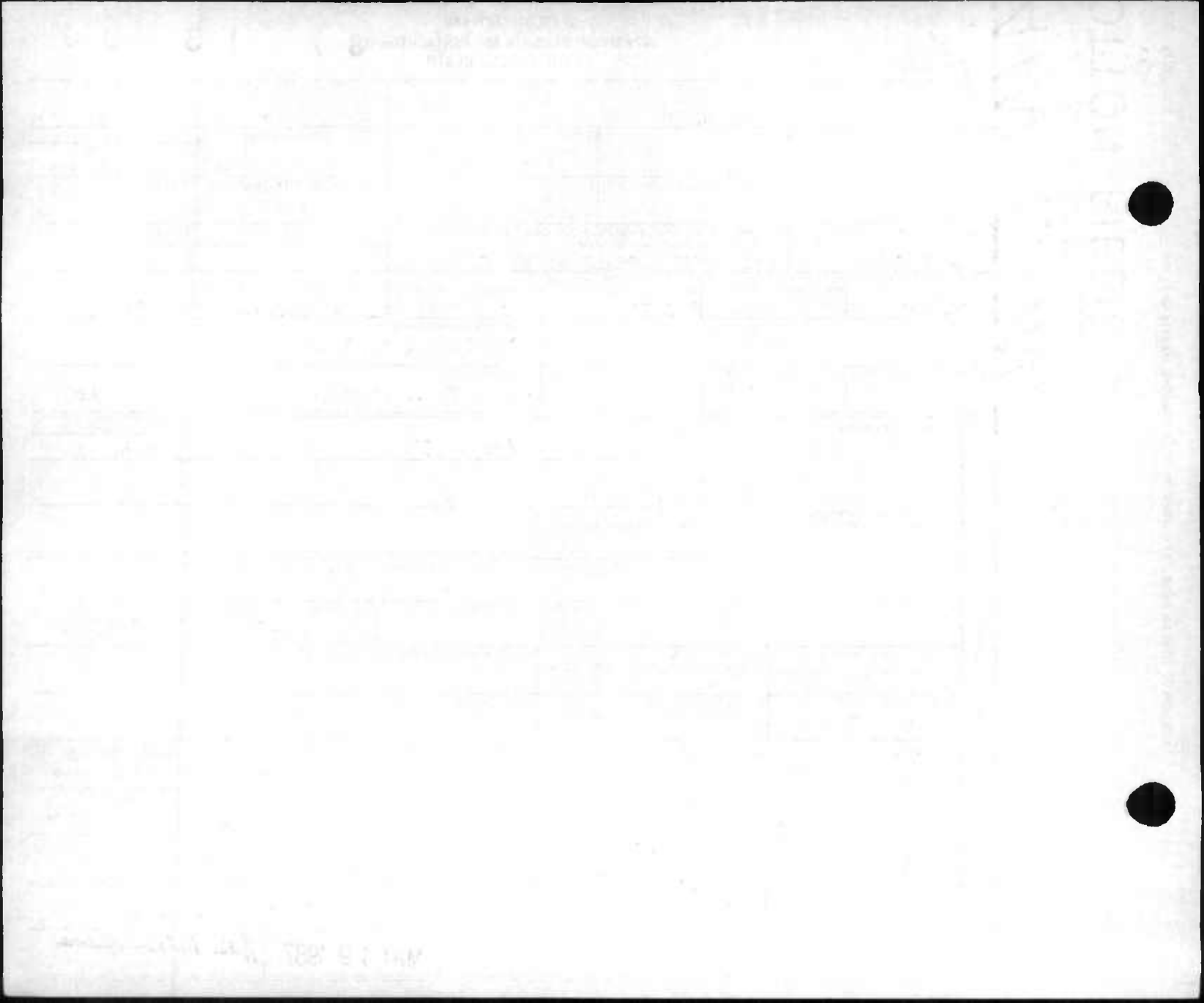
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		TWIN A BABY BOY FRANKLIN		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 05/13/1987		7a. DATE OF DEATH MONTH DAY YEAR MAY 13, 1987		7b. HOUR 5:30P M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 05/13/1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 4 30		IF UNDER 1 YEAR MONTHS DAYS 4 30		IF UNDER 72 HRS HOURS MIN. 4 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 1724 BRADDISH AVE. 21216		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BALTIMORE		15. MOTHER'S MAIDEN NAME ROSALIND Z. FRANKLIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ROSALIND Z. FRANKLIN		ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EXTREME PREMATUREITY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>87</u> to <u>5-13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Michael G. Cher</u> MD	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>87</u> to <u>5-13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Michael G. Cher</u> MD		22c. DATE SIGNED 5/13/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael G. Cher		22e. ADDRESS Johns Hopkins Hospital		22f. DATE REC'D. BY REGISTRAR MAY 19 1987	
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 5/14/87		23c. NAME OF CEMETERY OR CREMATORY JHH		23d. LOCATION BALTIMORE, MD. 21205		23e. DATE REC'D. BY REGISTRAR MAY 19 1987		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. DATE REC'D. BY REGISTRAR MAY 19 1987		25d. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the attending physician's name and address should be detached for use as the burial/transfer permit. Then please remove the permit from this certificate and deliver it to the funeral home with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a physician.

HP
DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID A. FRANKLIN			2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1987			2b. HOUR 3:26A M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 7 30		6. AGE (IN YEARS, LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2322 E. Oliver St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Barrett Franklin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219322335		17. INFORMANT ADDRESS Mrs. Barbara Jones 2322 E. Oliver St. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>prior cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe pneumonia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>5 days</u> <u>7 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>87</u> , to <u>5/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE <u>Cynthia S. Croner MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/3/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Cynthia S. Croner MD</u>			22e. ADDRESS <u>Johns Hopkins Hospital, Baltimore, MD</u>						
23a. BURIAL, CREMATION, REMOVAL (SPRINT) Burial		23b. DATE 5/7/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR MAY 5 - 1987					

REGISTRAR'S SIGNATURE
John E. Egan

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

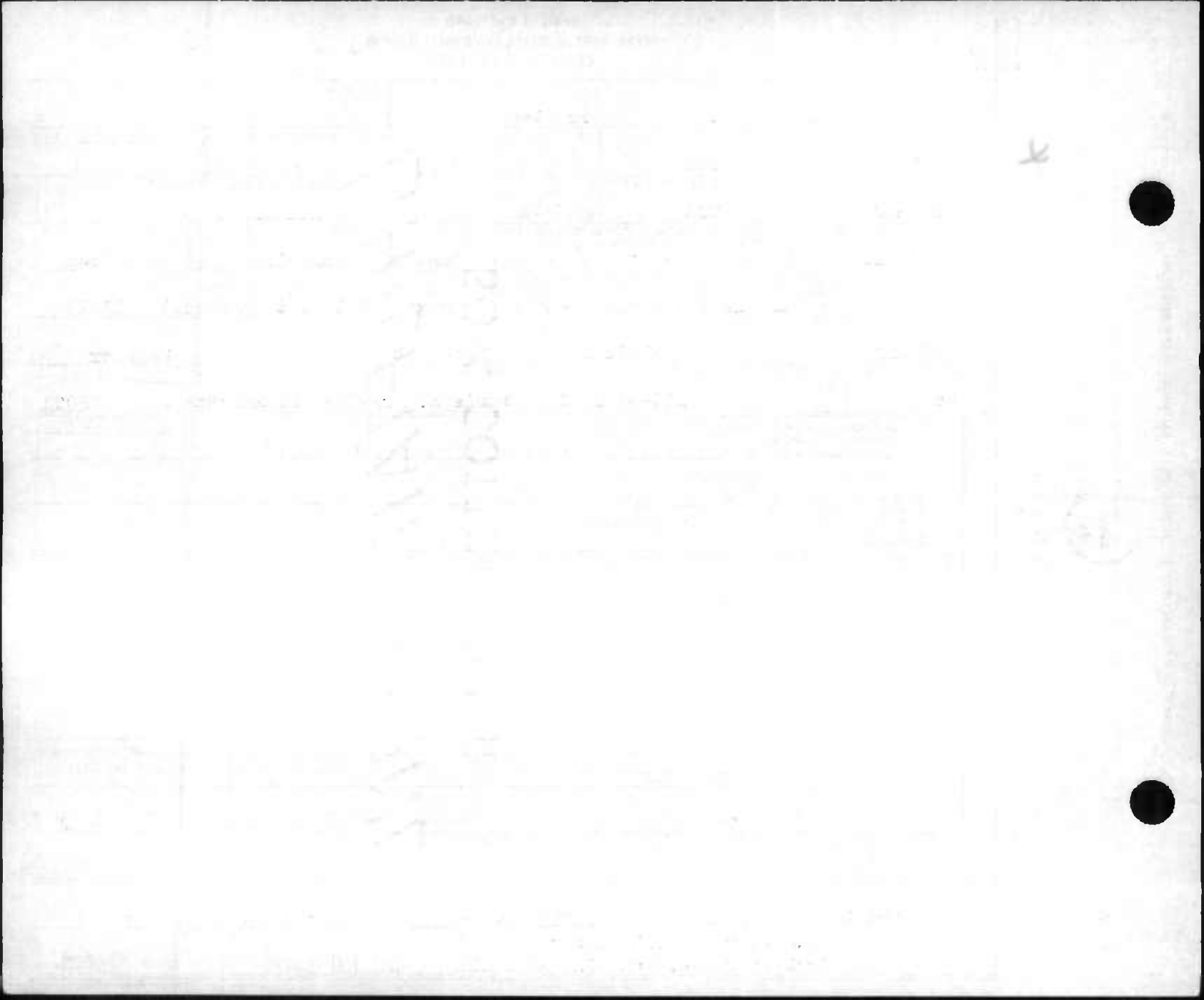
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna M. Frawley		2a. DATE OF DEATH MONTH DAY YEAR 5 / 12 / 87		2b. HOUR 12:50 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 / 26 / 1977	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13. STREET ADDRESS / ZIP CODE 501 S. 48th Street 21224	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Shelton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hassner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 216-54-3262		17. INFORMANT Louis E. Frawley		ADDRESS 33 Margate Rd 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Schemic bowel</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>GI bleeding</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B Fleming</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B Fleming</u>		22e. ADDRESS <u>Francis Scott Key Medical Ctr</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222			
25a. DATE REC'D. BY REGISTRAR MAY 14 1987		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 13506			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rita Freedman				2a. DATE OF DEATH MONTH DAY YEAR 5 18 87			
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 12 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt. city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13. USUAL RESIDENCE (IF HUNTING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD BALTIMORE				13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS MARKS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE SLUTZKIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 125-263218		17. INFORMANT ADDRESS MILTON FREEDMAN APT. 404 2 CANDLEMAKER CT. BALTO., MD 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary anest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration of gastric content</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>meningioma, meningitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 60 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH							
19a. DATE OF OPERATION 3/19/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED occipital meningioma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AID WHITE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from May 18 19 87, to May 18 19 87, and that (2) (we) lost saw the deceased alive on above, (1) (we) (did) (did not) view the body after death. (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE A. William Davis				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. William Davis				22e. ADDRESS Sinai Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 20, 1987		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 1010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAY 27 1987			
				25b. REGISTRAR'S SIGNATURE John F. ...			

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1909

AND BY THE ASSEMBLY

APRIL 1, 1909

AND BY THE SENATE

APRIL 1, 1909

AND BY THE ASSEMBLY

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APRIL 1, 1909

AND BY THE ASSEMBLY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

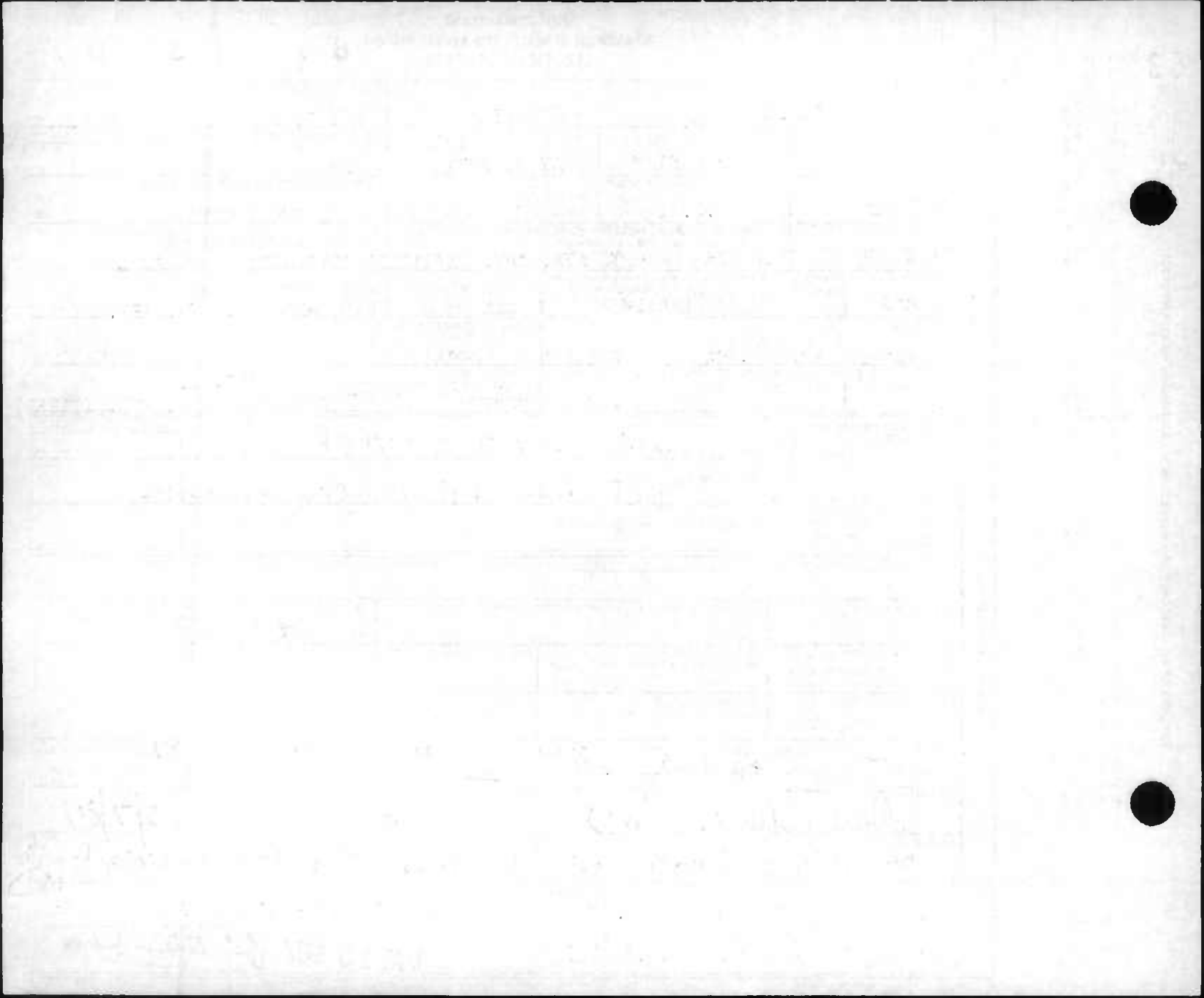
8713507

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERWIN B. FRENKIL			2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1987		2b. HOUR 7 A M M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1928		6. AGE (IN YEARS (LAST BIRTHDAY)) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7000 PARK HEIGHTS AVE., APT. M1 (21215)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY AT LAW	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL MARK AMRK FRENKIL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA SIEGEL		13e. STREET ADDRESS / ZIP CODE 7000 PARK HTS. AVE., APT. M1 (21215)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-3366		17. INFORMANT ADDRESS MARY ELLEN FRENKIL APT. M1 7000 PARK HTS. AVE. (21215)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/86</u> , 19 <u>86</u> to <u>MAY 7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>David S. Estlinger MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/7/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. ESTLINGER MD				22e. ADDRESS The Johns Hopkins Oncology Center Balto			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/10/87		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, BALTO MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAY 13 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13508

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LILLIE	MIDDLE E.	LAST RANDOLPH (FRIDLEY)	2a. DATE OF DEATH MONTH DAY YEAR MAY 6, 1987	2b. HOUR 7:35 P. M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9-24-1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY TAILORING	
13a. STATE MD.				13b. COUNTY BALTO.	13c. STREET ADDRESS / ZIP CODE 513 N. LAKEWOOD AVE. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST BROWNIE RANDOLPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-24-8092A		17. INFORMANT ADDRESS Mr. Fritz F. Fridley - 116 Glen Dr. Glen Burnie 21061		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO-PULMONARY ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>20 HRS</u> <u>>10 YRS.</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> 19 <u>87</u> , to <u>5/6</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>B. WARD</u>				DEGREE M.D.	22c. DATE SIGNED 5/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. WARD				22e. ADDRESS JOHNS HOPKINS HOSPITAL - BALTIMORE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-9-87	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILLS Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME <u>Jeffrey Hill</u>				25a. DATE REC'D. BY REGISTRAR MAY 8 1987		

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

13509

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and send them with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER FRISINO		2a. DATE OF DEATH MONTH DAY YEAR 5 24 87		2b. HOUR M	
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 6 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1802 Eutaw Place 21217
14. FATHER'S NAME FIRST MIDDLE LAST JAMES MARTIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE FOWLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown		16b. SOCIAL SECURITY NO. 216-01-5788		17. INFORMANT ADDRESS HENRY GULDBAUM 1802 Eutaw Place.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (1) Pneumonia (2) Hemorrhage (3) AIDS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/12 19 87 to 5/24 19 87, that (I) (we) last saw the deceased alive on 5/23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE W. J. D.		DEGREE MD.		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	
23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.		25a. DATE REC'D. BY REGISTRAR MAY 26 1987			
24. FUNERAL DIRECTOR NAME March Funeral Home		ADDRESS 1101 E. North Ave.		25b. REGISTRAR'S SIGNATURE	

BP

10

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 13510

1. DECEASED NAME (TYPE OR PRINT) Margaret M. Fritsch		2a. DATE OF DEATH MONTH DAY YEAR May 3, 1987		2b. HOUR 6:30 P.M.	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR March 31, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4257 NICHOLAS AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. STATE MD.		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-01-7117	17. INFORMANT ADDRESS EVELYN FRITSCH (DGHTR) SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Colonic tumor, diverticulitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 3-8, 19 83, to 5-3, 19 87, that (we) last saw the deceased alive on 4-14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GEORGE LOWE		22e. ADDRESS 3703 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/6/87	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.
24. FUNERAL HOME NAME ADDRESS SCHUMNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213			25. DATE REC'D BY REGISTRAR MAY 6 1987		
26. REGISTRAR'S SIGNATURE [Signature]			27. REGISTRAR'S SIGNATURE [Signature]		

NOTION 1002



055046 JUN - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13511

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillie E. Fulmore			2a. DATE OF DEATH MONTH DAY YEAR May 27 1987		2b. HOUR 1:05 A.M.
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 12 23 1948		6. AGE (IN YEARS LAST BIRTHDAY) 38	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST James Fulmore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella McGill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Iola Wilson 2226 Frederick Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 87 , to 5/27/87 , 19 87 , that (I) (we) lost saw the deceased alive on 5/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Betsy A. Faye		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Betsy A. Faye		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/31/87	23c. NAME OF CEMETERY OR CREMATORY Jerusalem Meth Church		23d. LOCATION CITY OR TOWN COUNTY STATE Kingstree S. C.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUN 1 1987			
		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

MEDICAL CERTIFICATION

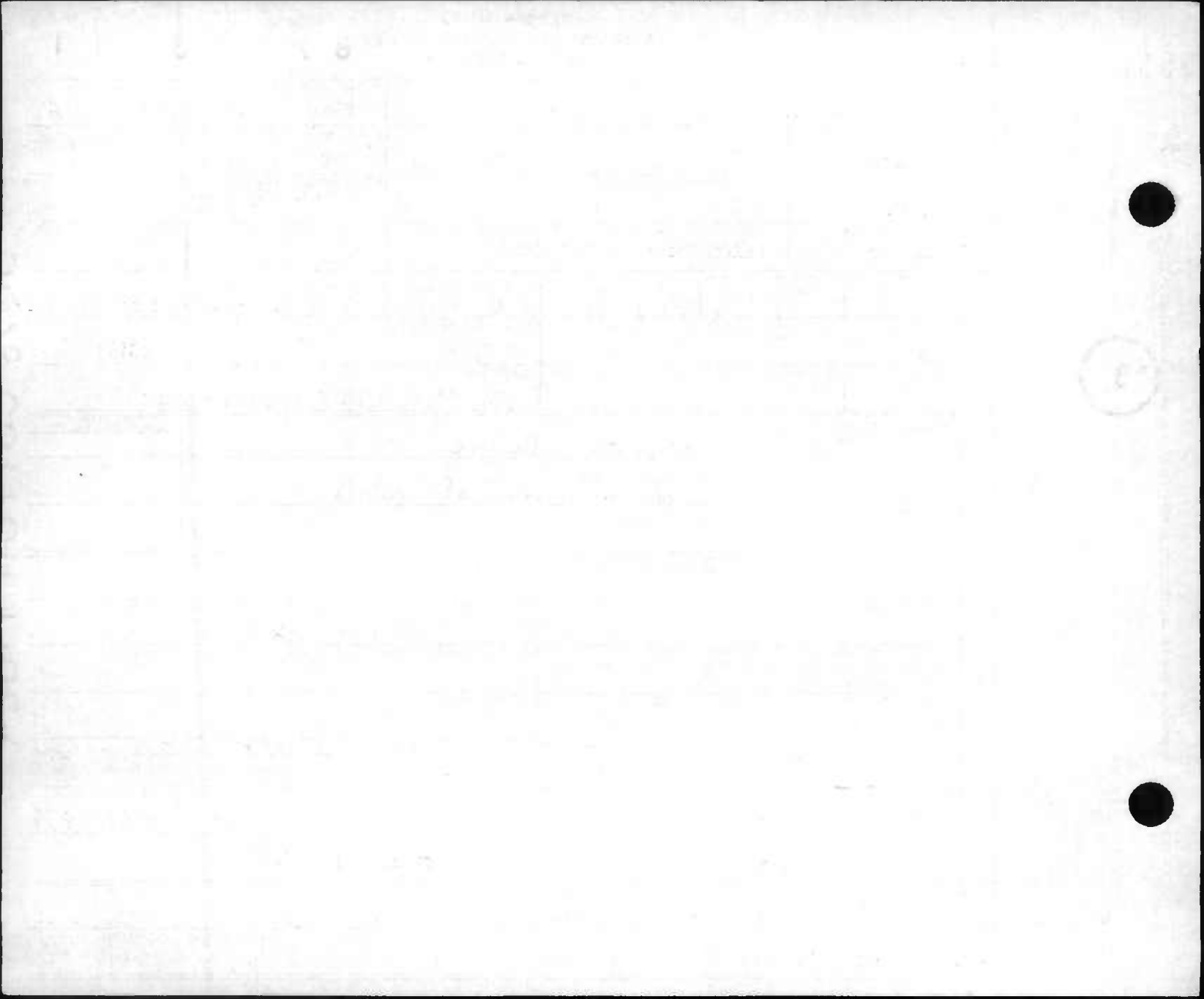
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Sarah Lee 2^d (Gaddis)

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

05 31 87 1142 AM

3. SEX

4. RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

Female

Black

09 19 05

81

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

VA

7b. CITIZEN OF WHAT COUNTRY?

USA

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

North Charles General

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Domestic

12b. KIND OF BUSINESS OR
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1324 N. Calhoun St. 21217

14. FATHER'S NAME

Henry

MIDDLE

LAST

Brown

15. MOTHER'S MAIDEN NAME

Beulah

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

217-30-5056

17. INFORMANT

ADDRESS

Frances McClain 1324 N. Calhoun St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Pneumonia & with Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

31 May 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

6/4/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem.

23d. LOCATION

Baltimore

COUNTY

MD

STATE

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H 1101 E. North Ave.

ADDRESS

25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUN 3 1987

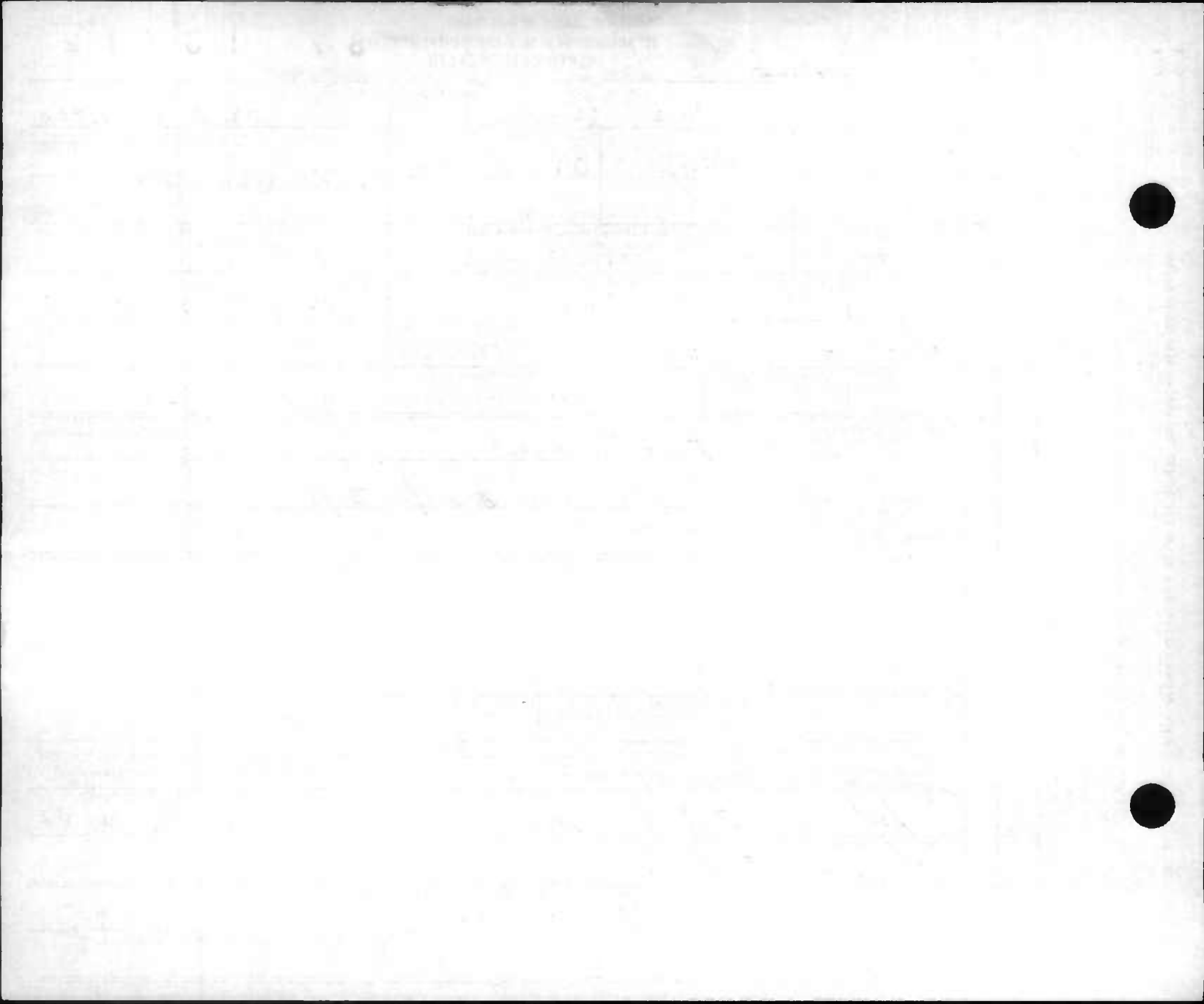
Gaila B. [Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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053515 MAY 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13513

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Larla Villa Gaines			2a. DATE OF DEATH MONTH DAY YEAR 5 10 87			2b. HOUR 1 ⁰⁰ A.M.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 17 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			

10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason Lord Chronic Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
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13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD Balto. City Baltimore			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 4920 Crenshaw Ave. 21206		
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14. FATHER'S NAME FIRST MIDDLE LAST Nephus Butter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 082 22 2066		17. INFORMANT ADDRESS Junius Butler 1002 N. Carolina St	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 <u>Chronic atrial fibrillation, decubiti, 1/2 subdural hematoma</u>			
--	--	--	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
--	--	--	--	---	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
--	--	--	--	---	--

22a. I certify that (I) (this hospital) attended the deceased from <u>4/21/87</u> to <u>5/10/87</u> that (I) (we) lost saw the deceased alive on <u>5/10/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
--	--	--	--

22b. SIGNATURE Douglas C. Powers MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/11/87	
--	--	--------------	--	--	--	-----------------------------	--

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas C. Powers		22e. ADDRESS 5200 Eastern Ave. 21224	
--	--	---	--

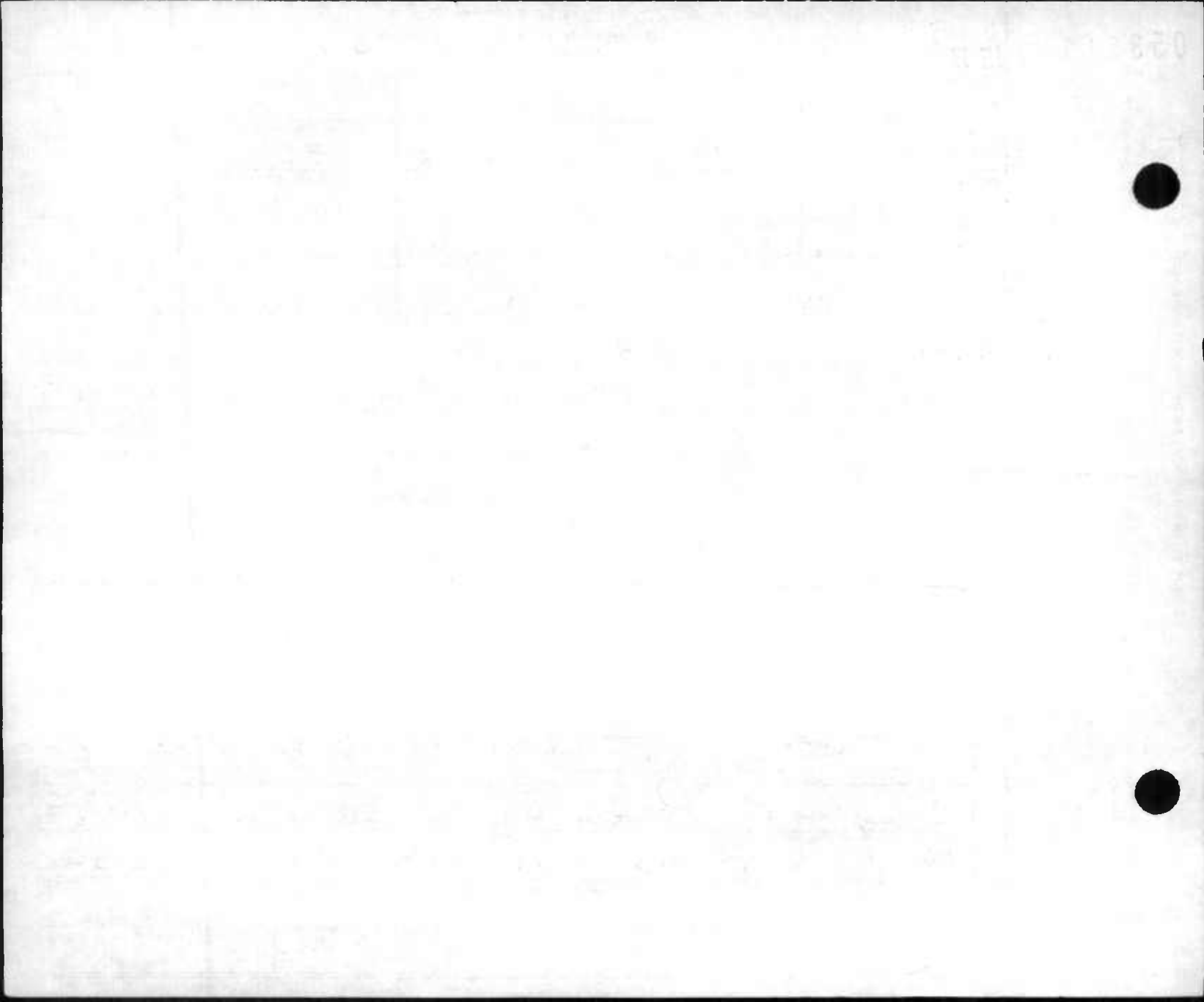
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Park Suitland Md		23d. LOCATION CITY OR TOWN COUNTY STATE	
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24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25. DAY RECEIVED BY REGISTRAR MAY 14 1987		26. REGISTRAR'S SIGNATURE	
--	--	--	--	---------------------------	--

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and examined.



54604 MAY 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified of same.

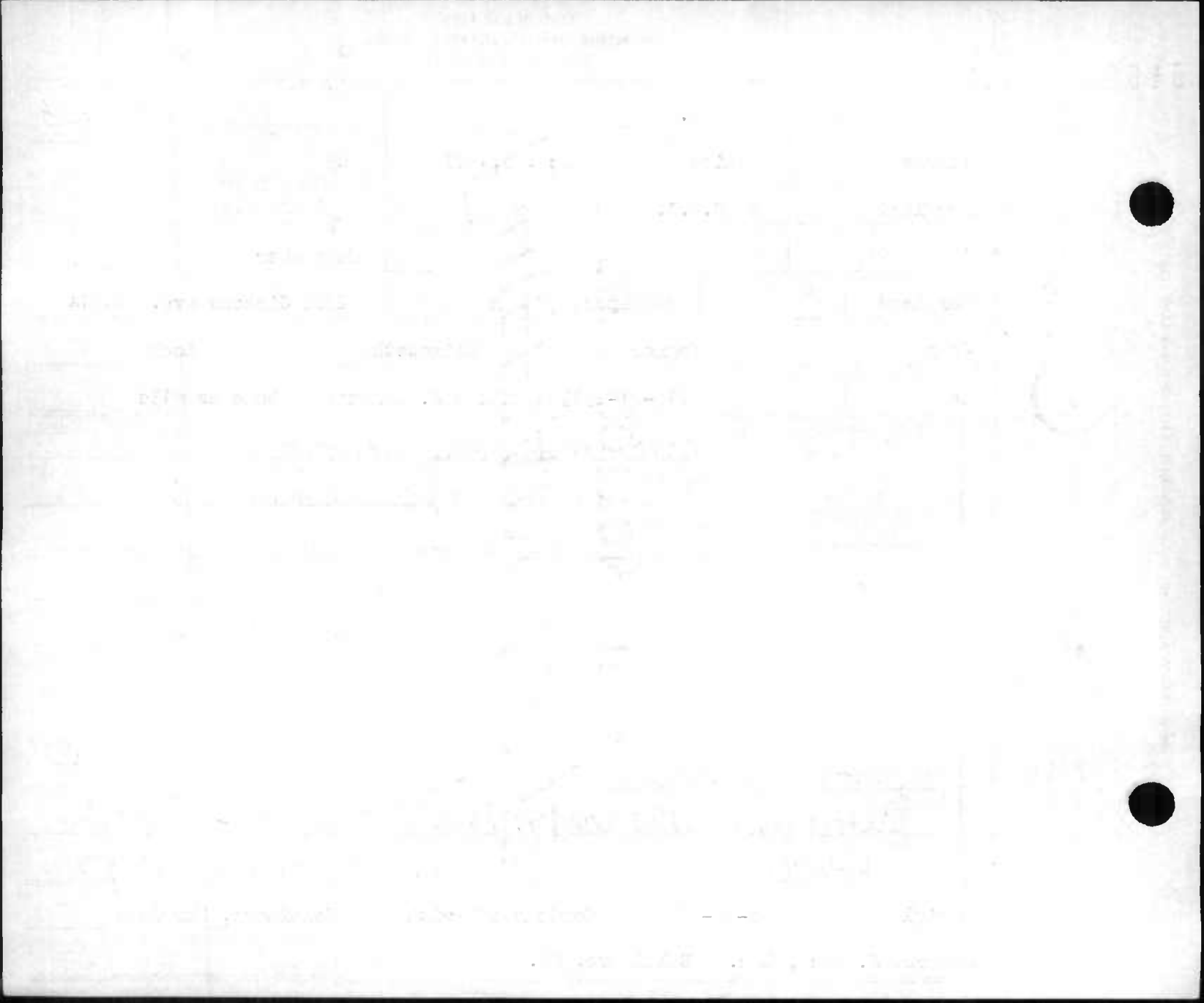
BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13514

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
P. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR	
Marie E. Galster		05 25 87		0235A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	Oct. 5, 1897	89	Baltimore City, MD	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City, MD		
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Union Memorial Hospital	Homemaker			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. STATE	18. COUNTY	19. CITY OR TOWN	20. INSIDE CITY LIMITS?	21. STREET ADDRESS / ZIP CODE
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2502 Gibbons Ave. 21214
22. FATHER'S NAME	23. MOTHER'S MAIDEN NAME	24. INFORMANT			
John Wagner	Elizabeth Look	Robert J. Galster			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	26. SOCIAL SECURITY NO.	27. ADDRESS			
No	218-01-2949	Same as #13e			
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio respiratory arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) Sepsis (pseudomonas)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
congestive heart failure					
29. DATE OF OPERATION	30. CONDITION FOR WHICH OPERATION WAS PERFORMED	31. AUTOPSY?	32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	34. TIME OF INJURY	35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
36. INJURY OCCURRED	37. PLACE OF INJURY	38. LOCATION			
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK	(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
39. I certify that (I) (this hospital) attended the deceased from 4/30 19 87 to 5/25 19 87, that (I) (we) last saw the deceased alive on 5/25 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
40. SIGNATURE	41. DEGREE	42. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		43. DATE SIGNED	
Catherine Marco, MD				5/25/87	
44. PHYSICIAN'S NAME (TYPE OR PRINT)	45. ADDRESS				
MARCO	Union Memorial Hosp				
46. BURIAL, CREMATION, REMOVAL (SPECIFY)	47. DATE	48. NAME OF CEMETERY OR CREMATORY		49. LOCATION	
Burial	5-28-87	Gardens of Faith		Baltimore, Maryland	
50. FUNERAL DIRECTOR		51. DATE REC'D. BY REGISTRAR		52. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Baltimore, Md.		MAY 26 1987		Julia Davis	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 1 5
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE Galvansky			2a. DATE OF DEATH MONTH DAY YEAR 5 11 87		2b. HOUR 0240 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 7 07		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MD	13b. COUNTY N BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8259 BRATTLE RD. 21208	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM BRIGHT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-09-0538		17. INFORMANT ADDRESS BELLE COGAN 4529 MARYKNOLL RD. 21208	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute MI DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/11 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE SINAI HOSPITAL	
22a. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 87 , to 5/11 , 19 87 , that (I) (we) last saw the deceased alive on 5/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Denise Cook MD		DEGREE HOUSE STAFF	22c. DATE SIGNED 5/4/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENISE COOK		22e. ADDRESS SINAI HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/12/87	23c. NAME OF CEMETERY OR CREMATORY XX BNAI REUBEN	23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215			25a. DATE REC'D. BY REGISTRAR MAY 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

23850



X

7/10/71

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

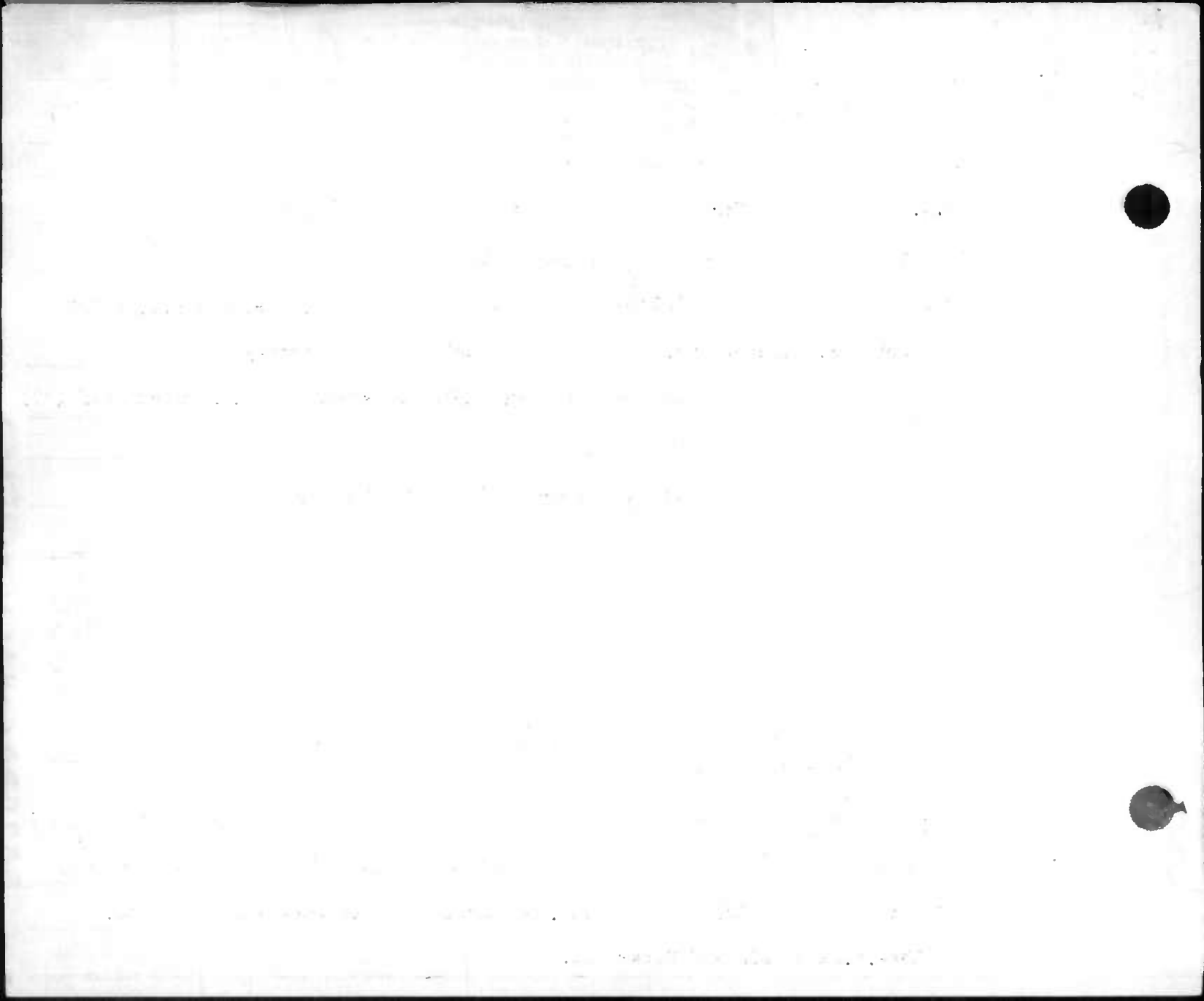
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713516

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		DATE OF DEATH		HOUR	
ROSA LEE GAMBLE		5 28 87		550 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	BLACK	10 10 27	59	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
S.C.	USA		Baltimore City MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Balt.	MERCY HOSPITAL				
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE	
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	301 S. Fremont Ave. 21230	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
John H. Dickey Sr.		Roberta Dickey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
		250-40-0416		Geraldine Anderson 301 S. Fremont Ave/ (30)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Meningeal Carcinomatosis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>Metastatic Breast Cancer</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>4/18</u> 19 <u>87</u> to <u>5/28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<u>Robert Anthenelli</u>		MD		5/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Robert Anthenelli MD		MERCY HOSPITAL Balt MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION
Burial		6/4/87	Balto. National		Catonsville COUNTY Md. STATE
24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Chas. A. Rice FSPA 1300 Eutaw Pl.			JUN 2 1987		<u>Julia Anderson-Randall</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

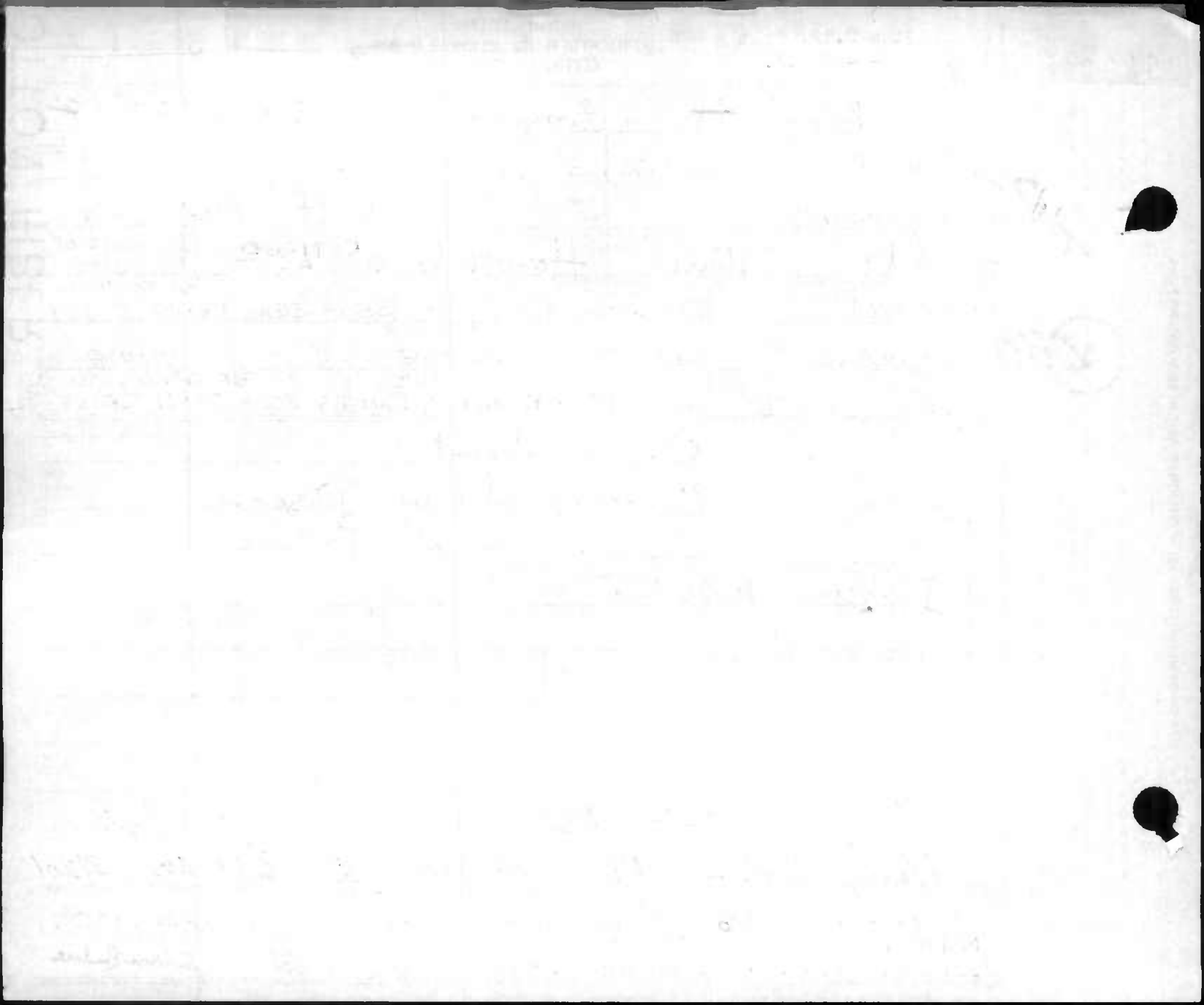
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR		Item 8.12. film g 628 6-2-87 I.J.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8713517	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roland H. Ganges.				2a. DATE OF DEATH MONTH DAY YEAR 05/23/87		2b. HOUR 1:34 M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 18 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. MD. (CITY) MD.	
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR EARNING LIFE) RETIRED SPECIALIST.		12b. KIND OF BUSINESS OR INDUSTRY Dept of Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROWLAND GANGES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE YOUNG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT MRS. YASHTI C. GANGES		ADDRESS BALTIMORE, MD. 21201	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) Diabetes Mellitus.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Young S Kim MD				DEGREE MD		22c. DATE SIGNED 5/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Young S Kim MD				22e. ADDRESS 22 Greene St Balt MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SUFFICIENCY)		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD, MD.	
24. FUNERAL HOME OR NAME NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTIMORE, MD.				25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

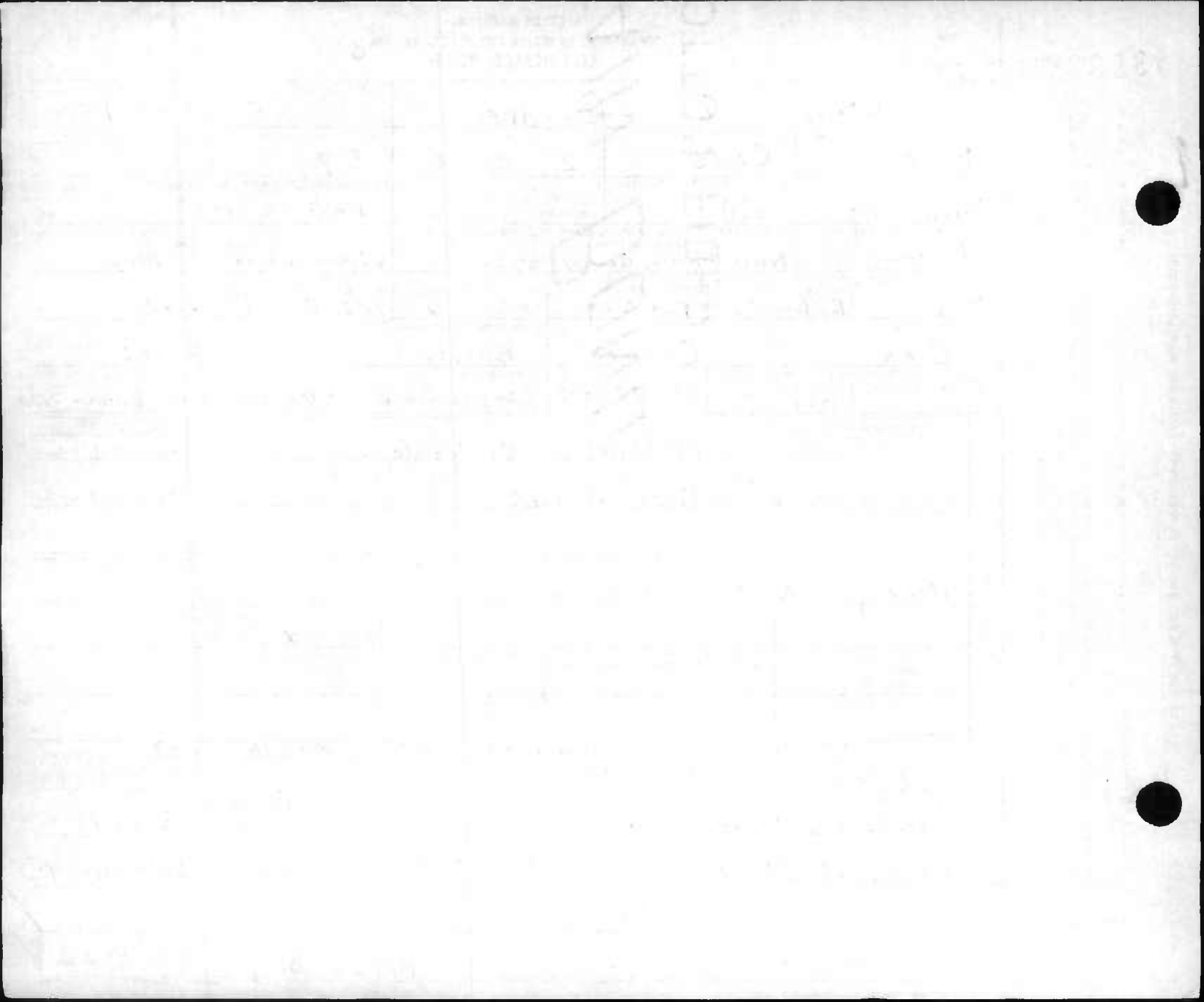
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry L Gardner		2a. DATE OF DEATH MONTH DAY YEAR 5 16 87		2b. HOUR 1:58 PM	
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 2 20 30	
6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll VA		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		10. CITY OR TOWN OF DEATH Baltimore, MD	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Army, retired		12b. KIND OF BUSINESS OR INDUSTRY Army	
13a. STATE MD		13b. COUNTY Baltimore Co.		13c. CITY OR TOWN East Point	
14. FATHER'S NAME FIRST MIDDLE LAST Glen Gardner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Ayres		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 1948-1971	
16b. SOCIAL SECURITY NO. 231-32-5805		17. INFORMANT Douglas Gardner		ADDRESS 4722 Dunroost Ave Baltimore 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metabolic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>liver failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about one year</u> <u>about one year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i): <u>leukopenia, thrombocytopenia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 22</u> , 19 <u>87</u> , to <u>May 16</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Miller, MD		DEGREE Resident		22c. DATE SIGNED 5/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Miller, M.D.		22e. ADDRESS North Charles General Hospital, Baltimore, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS ConnellyFuneralHome 300MaceAve. 21221			
25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



059873 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8713519	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN F. GARNER						2a. DATE OF DEATH MONTH DAY YEAR 5-16-87				2b. HOUR MIN. 4:05 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4-23-21		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66		IF UNDER 1 YEAR MONTHS DAYS 27		IF UNDER 24 HRS. HOURS MIN. 4	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7208 1/2 HARFORD RD. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD L. SPINKS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEANNA PARDEE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-12-3243		17. INFORMANT NAME ADDRESS Mr. Frank R. Garner, III - 4613 Quaker Run 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED METASTATIC CA DUE TO, OR AS A CONSEQUENCE OF (c) 20 minutes										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (it) (this hospital) attended the deceased from 05/06 , 19 87 , to 05/16 , 19 87 , that (I) (we) last saw the deceased alive on 05/16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. F. Krawltz						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 05/16/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FARSI KRAWLTZ				22e. ADDRESS GST							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-19-87		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24. FUNERAL DIRECTOR NAME ADDRESS Harley Miller - 7527 Harford Rd.						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR MAY 18 1987					

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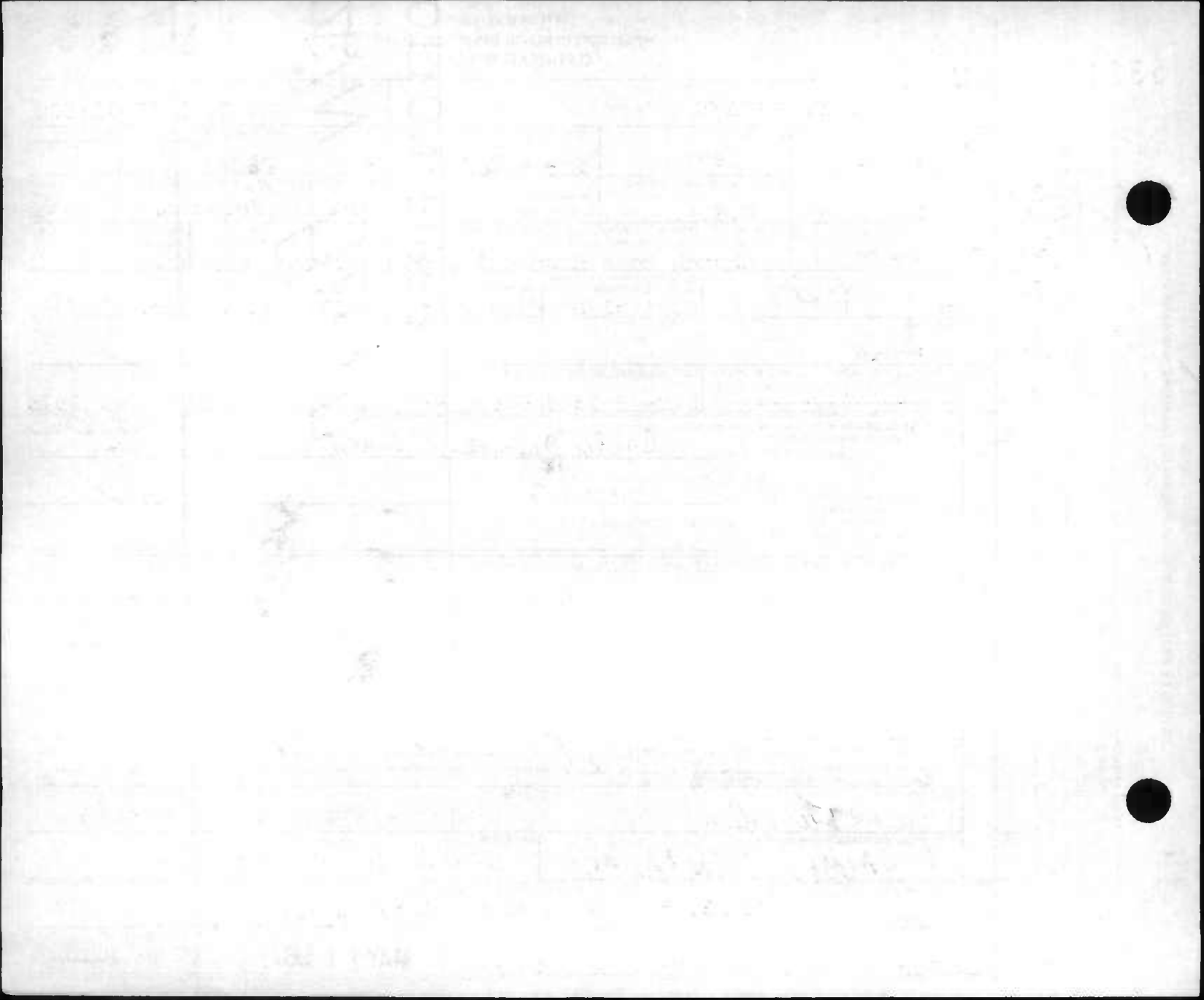
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as "not at work", item 15 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 7 1 3 5 2 0			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CORA GASKINS				2a. DATE OF DEATH MONTH DAY YEAR MAY 8, 1987		2b. HOUR 11:50 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug 31, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 RS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Capital Heights	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. COUNTY P. H.		13c. CITY OR TOWN Capital Heights	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 579-26-9528		17. INFORMANT Grace Wright, 6809 Sisalbed Dr., 20743			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 4 hrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AI WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-8, 19 87, to 5-8, 19 87, that (I) (we) last saw the deceased alive on 5-8, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jaime Punzalan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAIME PUNZALAN				22e. ADDRESS 5214 Harford Rd. Balt. Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 13, 87		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave.				25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13521

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Boy Gavin (mom-Lisa)			2a. DATE OF DEATH MONTH DAY YEAR 5 21-87		2b. HOUR 3:17 M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 21 87		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 3h 17mins	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA -MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) newborn		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Gavin		15. MOTHER'S MARRIAGE NAME FIRST MIDDLE LAST Lisa A Gavin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immaturity</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Beth Ann Thomas</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-26-87		23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME Sinai Hospital		ADDRESS 2401 W. Belvidere Ave		25. DATE RECEIVED BY REGISTRAR JUN 01 1987		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

THE UNIVERSITY OF CHICAGO
LIBRARY



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 2 2
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		John (nmn) Geci, Sr.		May 13 1987
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YEAR MONTHS DAYS
Male	White	1 MONTH 7 DAY 1916	71	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania	USA		Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Francis Scott Key Medical Center		Retired	Upholstery
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland Baltimore		Dundalk	13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Michael Geci		Anna Mihalo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		Anna Geci same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u>				1 hour
(c) <u>Atherosclerosis</u>				1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1985, 19 to 1987, that (I) (we) lost the deceased alive on 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>F.E. Chatham</u>		22c. DATE SIGNED		DEGREE <u>M.D.</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>F.E. Chatham</u>		22e. ADDRESS <u>1012 Old North Blvd., Baltimore, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	5-16-87	St. Stanislaus	Baltimore Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Duda-Ruck Funeral Home 7922 Wise ave 21222		MAY 14 1987		<u>Lidia Davidson-Randall</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

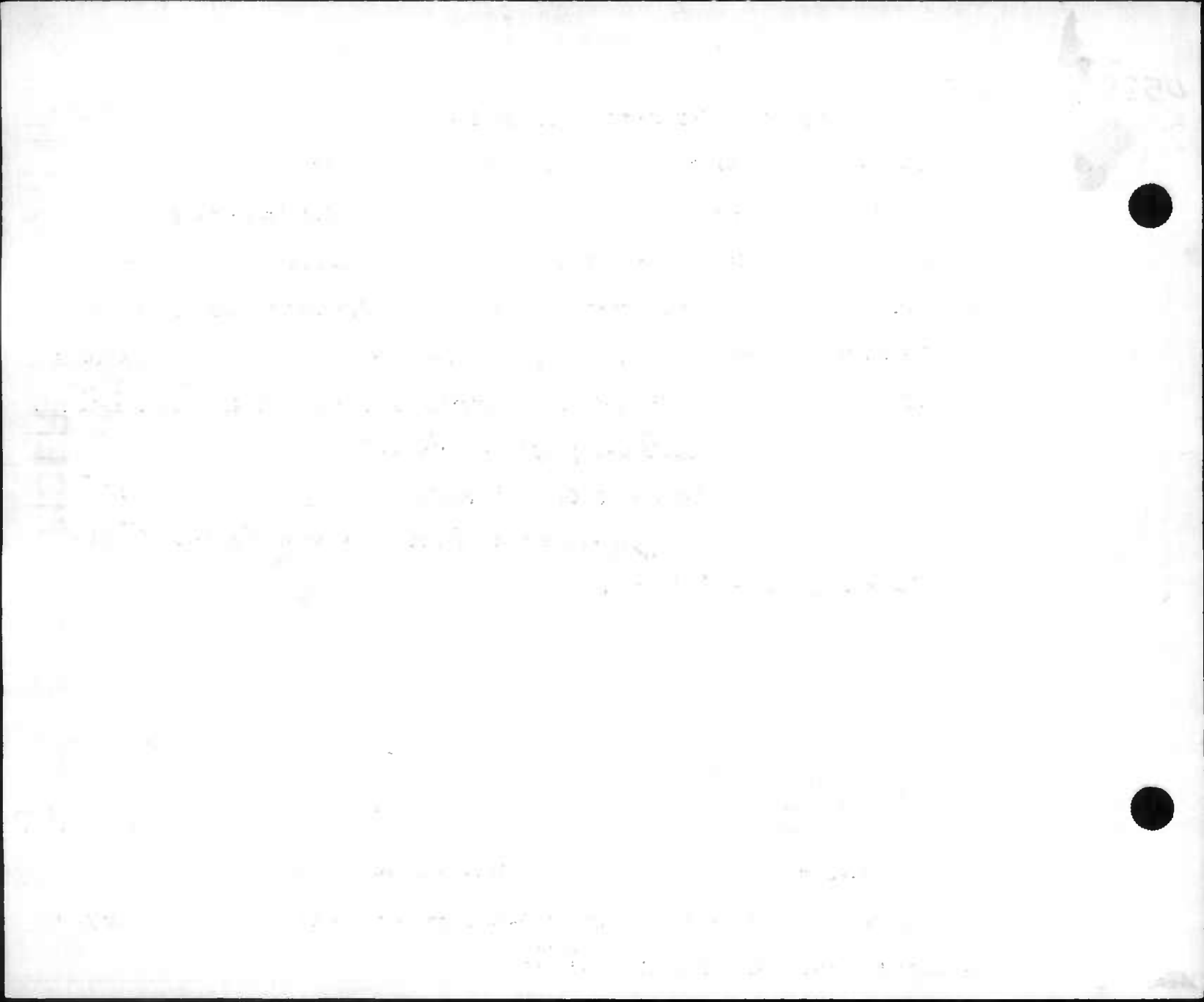
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 2 3

1 FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Elizabeth Geldmacher			2a. DATE OF DEATH MONTH DAY YEAR 5 2 87		2b. HOUR 3:15P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 3 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 418 Furrow Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 418 Furrow Street 21223
14. FATHER'S NAME FIRST MIDDLE LAST Clarence John Yost		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta O'Brien			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-12-8263	17. INFORMANT ADDRESS Elizabeth L. Schumacher 11 C Blue Teal Rd. 19975		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension & Chronic Renal Failure 3⁺ yrs.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 ⁺ yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Severe Osteoarthritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3 19 82, to 4 19 87, that (I) (we) last saw the deceased alive on 4/24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE MD		22c. DATE SIGNED 5-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.P. Malayaman		22e. ADDRESS 4001 Wilkens Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/6/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR MAY 4 1987	25b. REGISTRAR'S SIGNATURE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	PM	AM
Guiseppe				Genco	5	5	87		11:30	PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE	CAU.	8 27 07		79		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
ITALY	USA			BALTO CITY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTO.	JOHNS HOPKINS		TAILOR		TAILOR						
13a. STATE											
MD											
13b. COUNTY											
BALTO											
13c. CITY OR TOWN											
BALTO											
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS / ZIP CODE											
1018 STILE ST. 21202											
14. FATHER'S NAME											
JASPER											
15. MOTHER'S MAIDEN NAME											
CLARA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)											
NO											
16b. SOCIAL SECURITY NO.											
213-36-4235											
17. INFORMANT											
ALBA LONETANI											
ADDRESS											
4609 FINDLAY RD 21206											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular event</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>substance</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 1987 to MAY 5 19 1987, that (I) (we) last saw the deceased alive on MAY 5 19 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
A. L. H.								MD.		5/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
A. SANT ANTONIO								901 EASTERN BLVD			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial				5-9-87		GARDENS OF FAITH			BALTO. MD		
24. FUNERAL DIRECTOR											
Frank J. Bell											
25a. DATE REC'D. BY REGISTRAR											
MAY 18 1987											
25b. REGISTRAR'S SIGNATURE											
Julia Gordon-Rudolph											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into several lines or paragraphs, but the specific words and sentences cannot be discerned. There are two circular punch holes visible on the right side of the page.

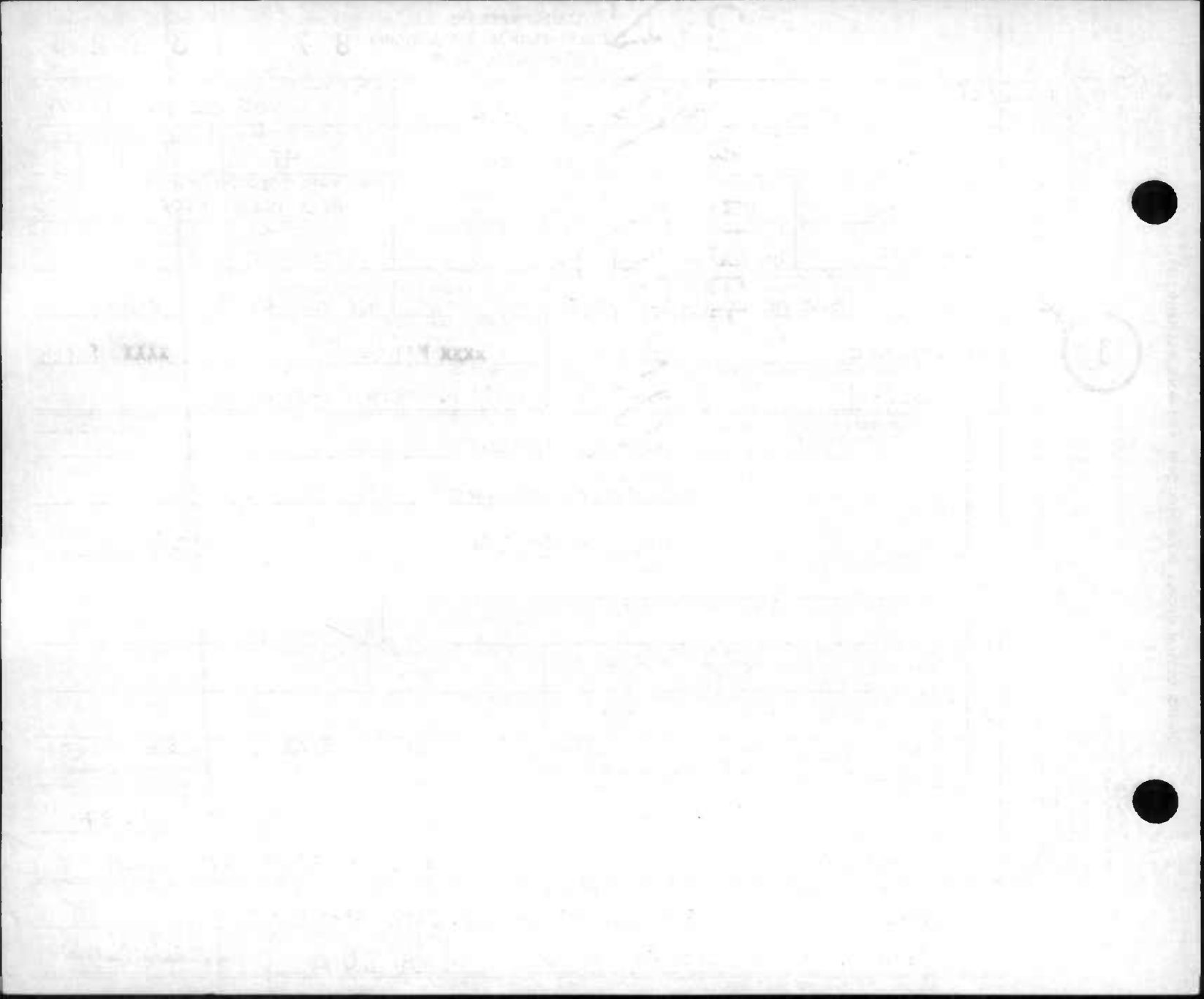
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13525

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GAIL GENE GEORGE			2a. DATE OF DEATH MONTH DAY YEAR 05 22 87		2b. HOUR 17:37 _M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 25 39		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY JANE ALLEN	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 408 BROOKS CT. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST NO CLARENCE BANKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred YERGEN Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 214-38-9092		17. INFORMANT David B. George, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>STATUS EPILEPTICUS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>87</u> , to <u>5/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Phyllis</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BECKER		22e. ADDRESS 22 S GREENE ST. BALTIMORE 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 26, 1987	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR MAY 26 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 2 6

1-7 FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Esther Gibson</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>5-3-87</i>		2b. HOUR M <i>7:40 A</i>	
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7 27 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balto City</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Villa St. Michael's Nsg Ctr</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD</i>		13b. COUNTY	13c. CITY OR TOWN <i>Balto</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Harrell</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>I. Nell Thomas</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>222-12-2178</i>		17. INFORMANT ADDRESS <i>Mr. Clement Gee 1824 E. 31 St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC LUNG CANCER</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>June 19 86</i> to <i>MAY 5 87</i> , that (1) we first saw the deceased on <i>5/3/87</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (1) I signed (and not view the body after death.					
22b. SIGNATURE <i>Scott R. F. KIN</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/3/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SCOTT R. F. KIN</i>		22e. ADDRESS <i>14 BARONERS CT 21117</i>			
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) <i>Burial</i>		23b. DATE <i>5-9-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>	
23d. LOCATION <i>Baltimore</i>		23e. COUNTY <i>Md.</i>		23f. STATE	
24. FUNERAL DIRECTOR NAME <i>March Funeral Home 1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 4 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page requires carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The State requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use on the burial-transit permit. Then, on the day of the funeral, the funeral director should notify the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner may be notified in advance.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST LOTHYOTT GIBSON		2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1987		2b. HOUR P 2:15	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 24 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Keller Gibson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Dora Pritt		13e. STREET ADDRESS / ZIP CODE 2141 East Fairmount Ave. 21231			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DIGITS) W.W. 2 236-30-4400		17. INFORMANT ADDRESS Lena Ayers 15047 SW. 280th St. Naronja, Fla.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOTENSION + DESOPHAGEAL VARICEL BLEEDINGS 5 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>END STAGE LIVER DISEASE.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mi.</u> <u>Sym.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 5/10/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING DESOPHAGEAL VARICES		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) this hospital attended the deceased from <u>5/11/87</u> 19 <u>87</u> to <u>5/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.							
22a. SIGNATURE John D. Grant M.D. BPO UCRP SE		DEGREE SE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 5/20/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) GRANT, JOHN A.		22d. ADDRESS JH. 600 N. Broadway Balto. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-23-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia D. [Signature]	

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recovered

1951, v. 1, p. 111

1951, v. 1, p. 111



1951, v. 1, p. 111

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then make copies of the certificate and page 3 and send them to the funeral home. The funeral home will send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA BELLE WOLFE GILDENF			2a. DATE OF DEATH MONTH DAY YEAR 5 18 87			2b. HOUR 145 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 10 18		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 403 #21210 1190 W. Northern Parkway	
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP J. CUSHNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIVIAN OISTACHER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-50-6125		17. INFORMANT MRS. SUSAN FRANK 57217 VERBENA RD. BALTO., MD 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>diffuse non-Hodgkin-Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 513 19 87 to 518 19 87, that (i) (we) last saw the deceased alive on 518 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Sabine Ross				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SABINE ROSS				22e. ADDRESS Sinai Hospital, Baltimore, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 19, 1987		23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE WOODMOOR HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAY 20 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Lindner			

MEDICAL CERTIFICATION

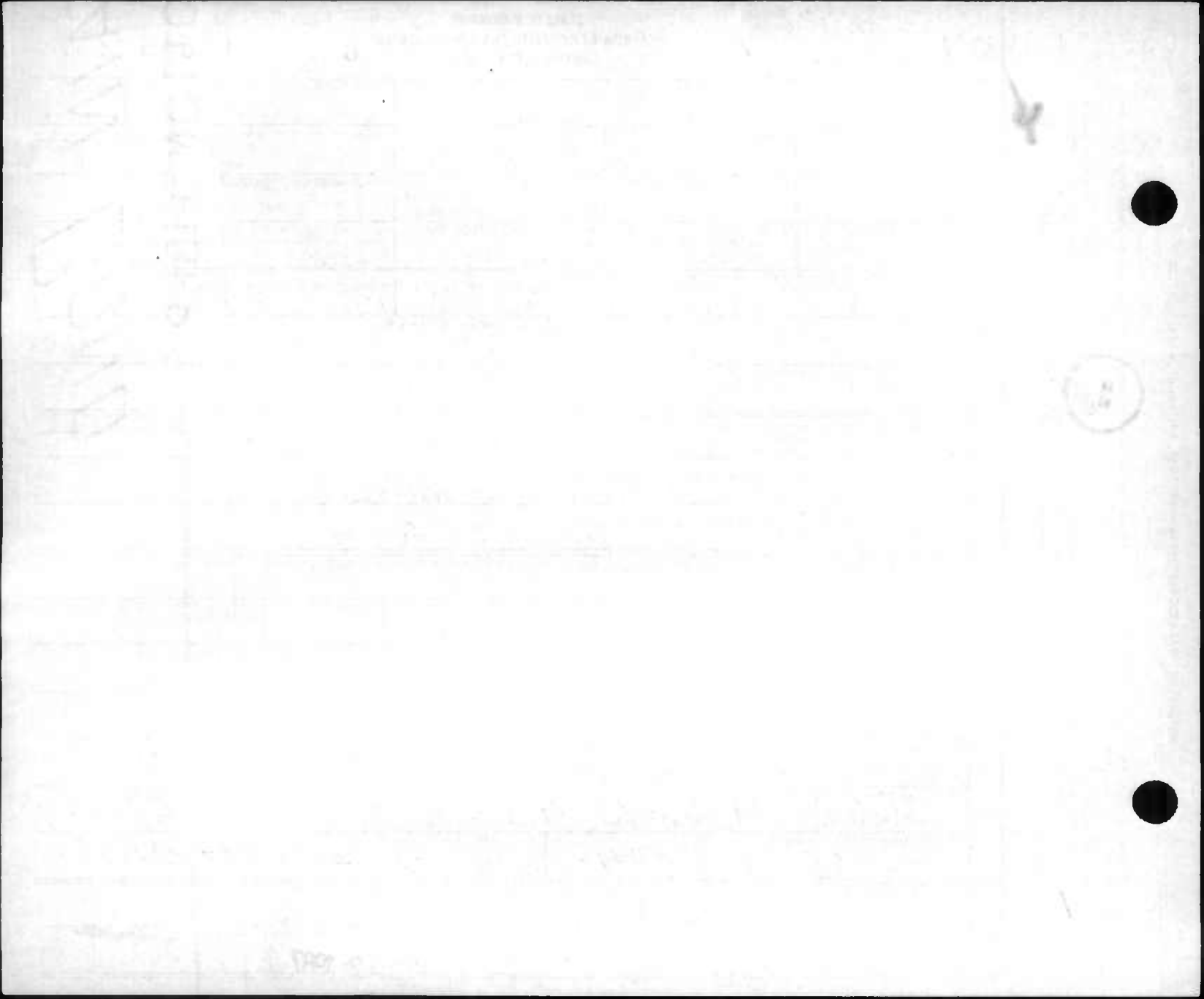
WAS O S YAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, and 6 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 13529 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph F. Giles				2a. DATE OF DEATH MONTH DAY YEAR May 6, 1987		2b. HOUR 04:08PM	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 8 23 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Maryland MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Giles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 213-10-5109		17. INFORMANT ADDRESS Henry Ward 1606 W. North Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) DM & CVA. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-7-85 , 19 85 , to 5-5 , 19 87 , that (I) (we) last saw the deceased alive on 5-5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gubali M. Shah MD DEGREE				22c. DATE SIGNED 5/11/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEULAB M. SHAH	
22e. ADDRESS 2105 N. Charles St 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/11/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE [Signature]	



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 5 3 0

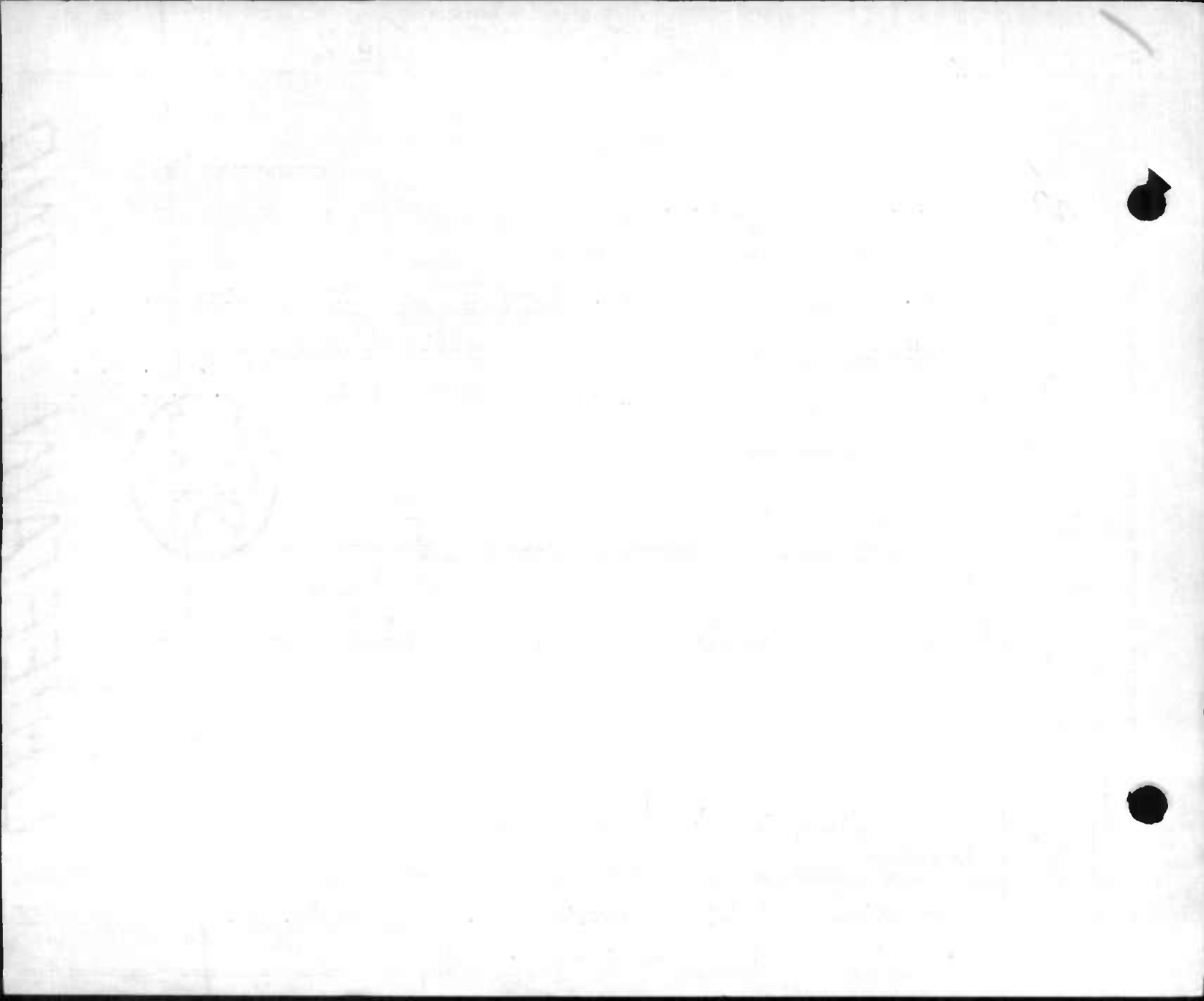
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Jasper						Gill		5-7		5-7		19									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
M		Black		6/7/07		79 YRS.		MONTHS		DAYS		HOURS		MIN		5-29		1987		10:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
S.C.		U.S.										Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		2172 Hollins Street																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.				Balto. City		YES <input type="checkbox"/> NO <input type="checkbox"/>		2172 Hollins St.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Unknown		Nettie Witherspoon																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT																	
yes		228-14-3932		Jasper Phelps																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b)																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
		P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
				STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Margarita A. Korell, M.D.		Assistant		5-30-87																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Margarita A. Korell, M.D.		111 Penn Street, Balto., Md 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Cremation		6/1/87		Westview Mem.		Balto., Md.															
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
C. Wainwright		JUN 1 1987		Jasper Witherspoon																	

NOTE TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. **NOTE TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINCESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
VR A15 ME (5))



052987 MAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please forward the carbon pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the police should be notified by the funeral director, page 3.

8-20-87

LEVINDALE

8-20-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13531

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST LOUIS	MIDDLE (nmi)	LAST GINSBURG	MONTH DAY YEAR 05-05-87			9:50P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04-29-1903	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			12b. KIND OF BUSINESS OR INDUSTRY Wholesale Grocer		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Wholesale Grocer		
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Ginsburg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Unknown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 816-01-7009			17. INFORMANT Dorothy G. Ginsburg (Wife) (Same as 13e)		
13e. STREET ADDRESS / ZIP CODE 2305 Crest Rd. 21209			13f. STREET ADDRESS / ZIP CODE 2305 Crest Rd. 21209			13g. STREET ADDRESS / ZIP CODE 2305 Crest Rd. 21209		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO, OR AS A CONSEQUENCE OF			
DUE TO, OR AS A CONSEQUENCE OF			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC RENAL FAILURE</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 8/3/87, 19 87, to 5/5/87, 19 87, that (we) last saw the deceased alive on 5/5/87, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>E. Estrelita</u>	DEGREE M.D.		22c. DATE SIGNED 5/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KU	22e. ADDRESS LEVINDALE HOSPITAL		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 5/7/1987	23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc. Dundalk Md. 21222		25a. DATE REC'D. BY REGISTRAR MAY 8 1987	
25b. REGISTRAR'S SIGNATURE <u>J. L. Landon</u>			

100-1-1007 2041-1007

CEC 88000-10-914

(1) - 0.68 ± 0.09

2
154819 JUN - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13532

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
PHILLIP		B.		GLADDEN				X		5 26 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male	Black	Oct. 14, 1962		24 YRS.						5 26 1987		A 15 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.										Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Middle Branch River		Laborer		Steel							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		21225		Baltimore		YES X NO		2398T Seamon Ave. 21225					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
James L. Gladden		Raymell Williams											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT									
No		213-82-7599		Lonarell A. Gladden		Baltimore, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Drowning</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED					
2				xxx 5-26- 19 87				Subject drowned.					
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X				21e. PLACE OF INJURY				21f. LOCATION					
				water				Middle Branch River, Balto. MD					
22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident X, Suicide, Homicide, Undetermined manner.													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Ann M. Dixon, M.D.				Deputy Chief				5-26-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Ann M. Dixon, M.D.				111 Penn St., Balto., MD				21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial		5/29/87		Arbutus Memorial Park		Arbutus				Md			
24. FUNERAL DIRECTOR													
George W. Tuttle Funeral Home, Jarrettsville, Md													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MAY 28 1987 Julia Scidmore-Pandey

20X COTTON FIBER

100% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed in turn by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

055017 JUN 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 13533	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LOVELEAN GLADNEY					2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1987			2b. HOUR 11:07pm			
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 4 9 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 48 N. Ellamont Street 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Dorsey Gladney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phobie Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Agnes Hill 7004 Queen Ann Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 13 , 19 87 , to MAY 22, 1987 , that (I) (we) last saw the deceased alive on MAY 22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>						DEGREE		22c. DATE SIGNED 5/22/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FACILITY E. Hoops, MD						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD				
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

CONFIDENTIAL

BP.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 7 1 3 5 3 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) George Glascoe			2a. DATE OF DEATH 5/15/87		2b. HOUR 10 ⁰² AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH 1/17/1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETAIL	
13a. STATE MD.		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. GLASCOE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZETER MOORE		16. SOCIAL SECURITY NO. 212-07-9021	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-07-9021		17. INFORMANT ADDRESS ROMONA GILES 3216 LAKE AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulmonary DS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs > yrs > yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive heart failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>87</u> , to <u>5/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jeanne Kinney, MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/15/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jeanne Kinney, MD</u>		22e. ADDRESS <u>Mercy Hosp</u> <u>301 St Paul St Balt. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-19-87	23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUDEL CO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS MARCH FUNERAL HOME 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Sanderson-Randall</u>	

PF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713535

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
William M. Glenn					5 15 87					50am
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS	
MALE	WHITE	MONTH DAY YEAR JUNE 9 1890			96		YRS.		MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
MD.	U.S.A.				BALTIMORE CITY					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	Garden Village Nursing Home			TOOL CONTROL			MARTINS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4217 SHAMROCK AVE.		21206
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
CHARLES GLENN				CORNELIA UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS						
NO		216-09-6304		DOROTHY FULLER (DGHTN) SAME ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>As CVD</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Urinary Tract Infection</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>JUN 1</u> 19 <u>87</u> to <u>May 15</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>May 11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Howard H. Bond</u>		MD					5/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Howard H. Bond, M.D.					9618 Belair Road, Balto, Md. 21236					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
BURIAL		5/18/87		PARKWOOD		BALTIMORE			MD.	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCHIMUNEK FUNERAL HOME, Balto, Md. 21213					MAY 19 1987		<u>Julia Davidson-Randall</u>			

BP

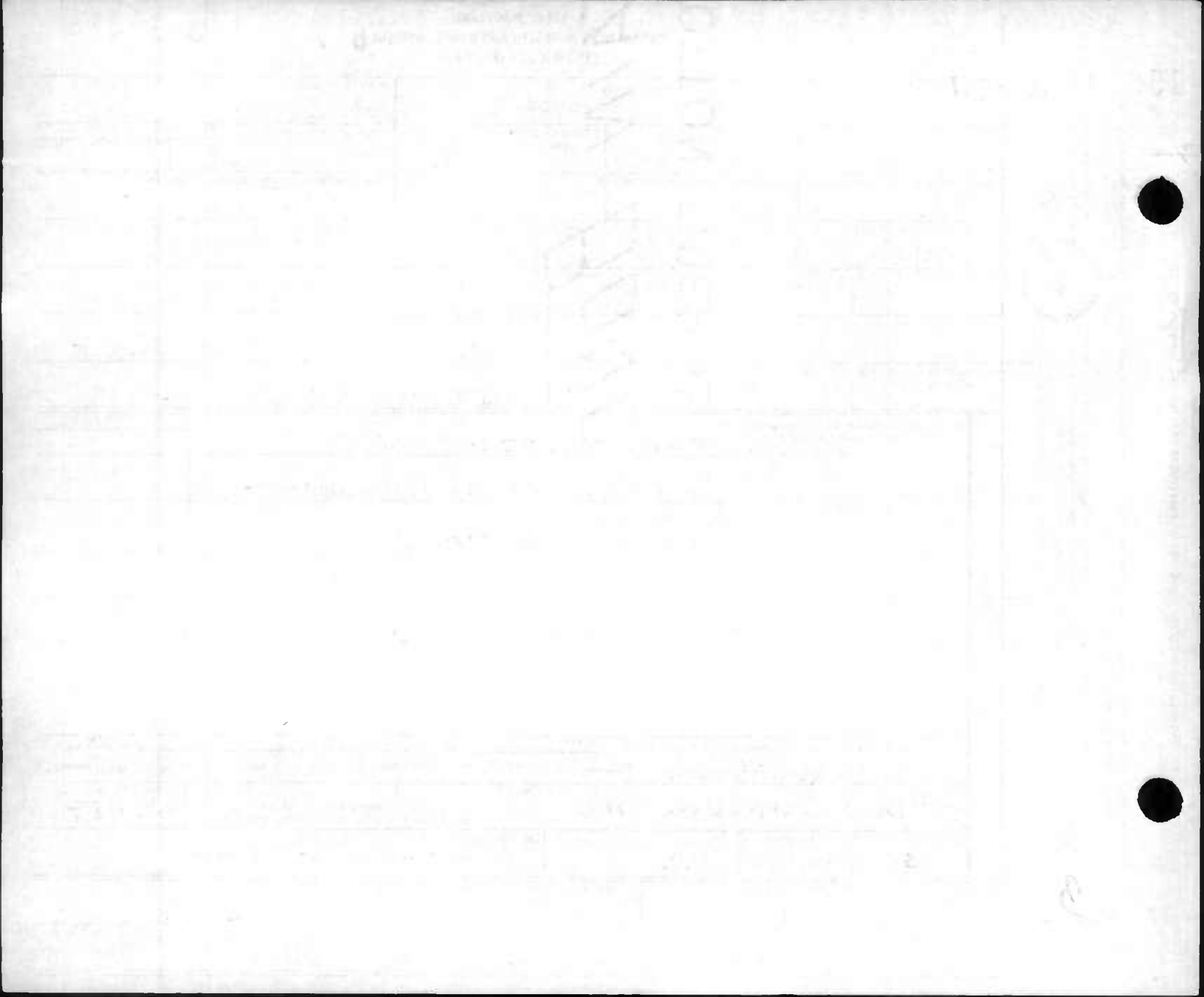
1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

055016 JUN 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	7	1	3	5	3	6
FOR 1- STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy L. Glenycamp										2a. DATE OF DEATH MONTH DAY YEAR May 22, 1987				2b. HOUR 06:35A M		
3. SEX Female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 7 13 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD										
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1511 Clifton Avenue 21217								
14. FATHER'S NAME FIRST MIDDLE LAST Edward Bruton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Williams Bruton												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219- 30-9740		17. INFORMANT ADDRESS Fred Glencamp 1511 Clifton Avenue										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffused Pseudomembraneous Colitis DUE TO, OR AS A CONSEQUENCE OF (b) Marked Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis; Left Ventricular Hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)																
19a. DATE OF OPERATION May 21, 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abdomen/Acute Renal Failure				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (X) (his hospital) attended the deceased from May 20, 19 87, to May 22, 19 87, that (X) (we) lost saw the deceased alive on May 22, 19 87, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) NOT view the body after death.																
22b. SIGNATURE Aysel K. Sanderson MD								DEGREE		22c. DATE SIGNED 5/23/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aysel K. Sanderson, M.D.						22e. ADDRESS c/o Maryland General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/26/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne ARUNDEL CO Md										
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 7 1 3 5 3 7	
REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose - Glorioso			2a. DATE OF DEATH MONTH DAY YEAR May 7, 1987		2b. HOUR 4:30 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 14, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1307 W. Northern Pkwy.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1307 W. Northern Pkwy. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Cinquegrani		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria G. Ciolino			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-2254	17. INFORMANT ADDRESS Enes Glorioso Same			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) STROKE					1-2 months
DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration					1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/30, 1986 to 5/7, 1987 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 4/22, 1987 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE John W. Bowie M.D.				22c. DATE SIGNED 5/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John W. Bowie M.D.				22e. ADDRESS 500 W. University Pkwy. Balt., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 11, 1987		23c. NAME OF CEMETERY OR CREMATORY New Cathedral	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		25a. DATE REC'D. BY REGISTRAR MAY 11 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE Lelia Davidson			

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December 11, 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

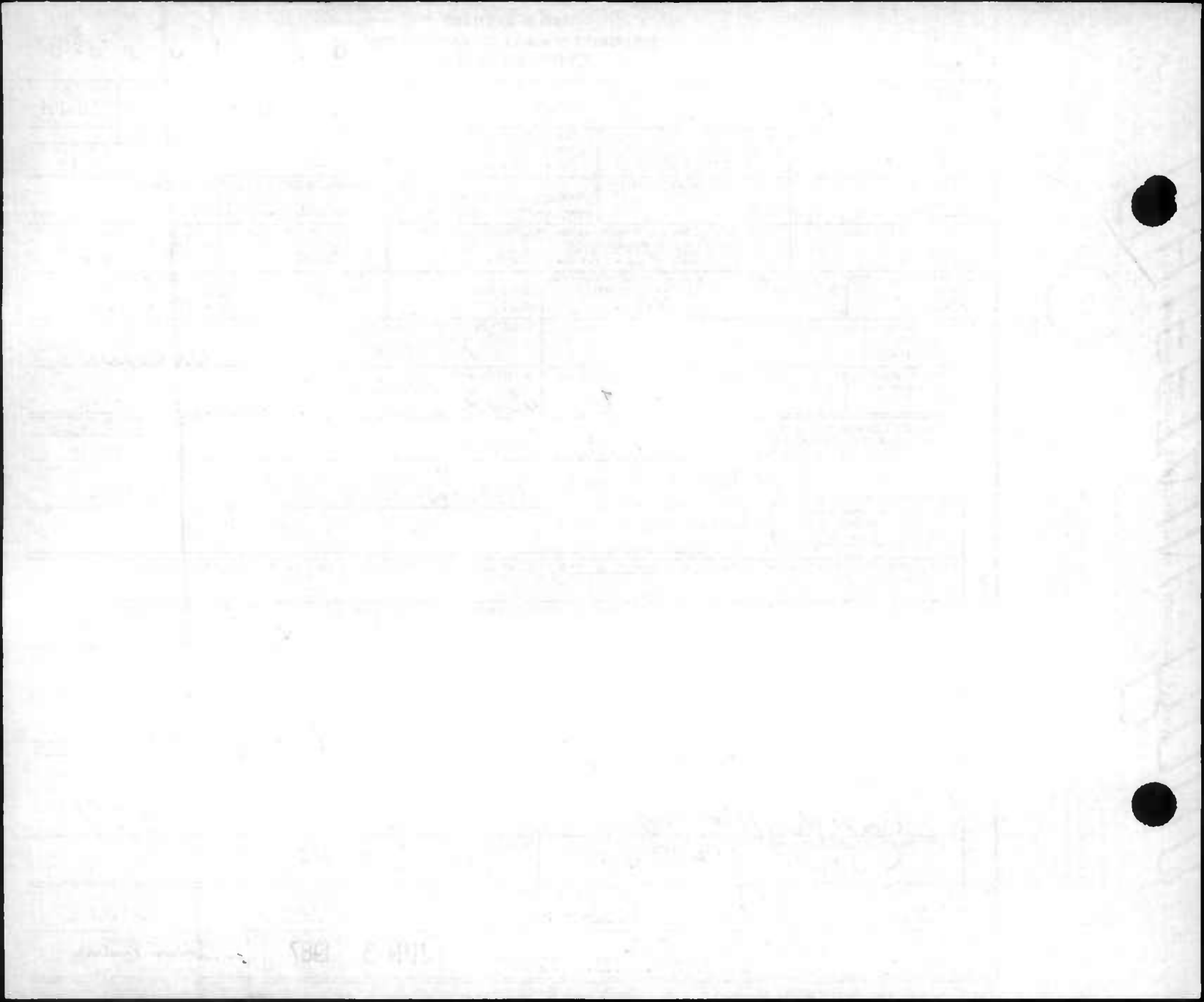
BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 3 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
FIRST MIDDLE LAST FLORA B. GOLD		MAY 28, 1987		10 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE	JAN. 26, 1904	83	YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	6807 PARK HTS. AVE., APT. 2B		BUYER	HESS SHOES	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	APT. 2B 6807 PARK HTS. AVE. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOSEPH GOLD		SARAH UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-09-7251		MAYER HANDELMAN 6602 SHELICK PL. BALTO., MD 21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>10 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
				1987 May 28 87	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Joseph Shear MD				5/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JOSEPH SHEAR MD		6715 PARK HEIGHTS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL	5/31/87	ANSHE EMUNAH		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR	
SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)				JUN 3 1987	
				25b. REGISTRAR'S SIGNATURE James D. Anderson	



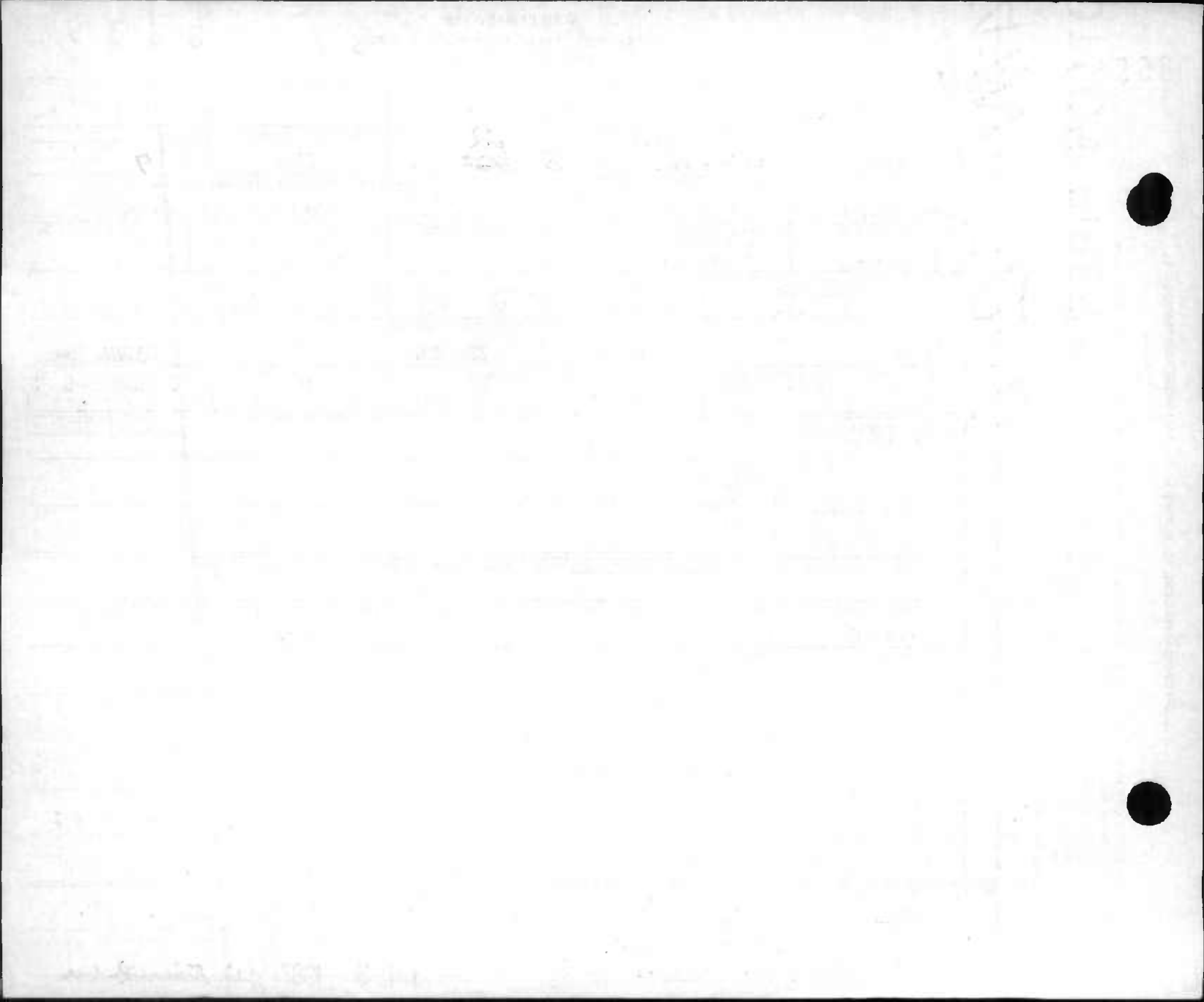
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6713539

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ORLY Golfeiz			2a. DATE OF DEATH MONTH DAY YEAR 5 29 87			2b. HOUR 148 P.M.					
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 22 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 0 2 9		IF UNDER 1 YEAR IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md			13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3325 Clarks Lane 21215		
14. FATHER'S NAME FIRST MIDDLE LAST Saleh Golfeiz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL DAFNA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. NONE	
17. INFORMANT Saleh Golfeiz			ADDRESS 3325 CLARKS LANE APT. C 21215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110											
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-29, 19 87, to 5-29, 19 87, that (I) (we) last saw the deceased alive on 5-29, 19 87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donna L. Snyder						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna L. Snyder MD						22e. ADDRESS Sinai Hospital, Baltimore, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY SHOMREI MISHMERES CEM			23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO., MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)						25a. DATE REC'D. BY REGISTRAR JUN 3 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1 3 5 4 0
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
KENETTE		GOODE					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Female	Black	12 29 79	7	MONTHS DAYS HOURS MIN		5-28-87 19	4-42P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		USA				Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Johns Hopkins Hospital		child			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD				Baltimore		415 E. Biddle St. 21202	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Kenneth Robinson				Blanche Goode			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				219-94-4418		Kenneth Robinson 415 E. Biddle St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Multiple injuries</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
				10:05PM 5-27-87			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			
pedestrian struck by a vehicle (motorcycle)				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			
				street			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				1200blk. Greenmount & Mura St. Balto., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				DATE SIGNED 5-29-87			
ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/5/87		Eastview Mem. Pk.		Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D BY REGISTRAR			
Wm. C. March F/H 1101 E. North Ave.				JUN 5 1987			
				25b. REGISTRAR'S SIGNATURE			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

00000000000000000000000000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

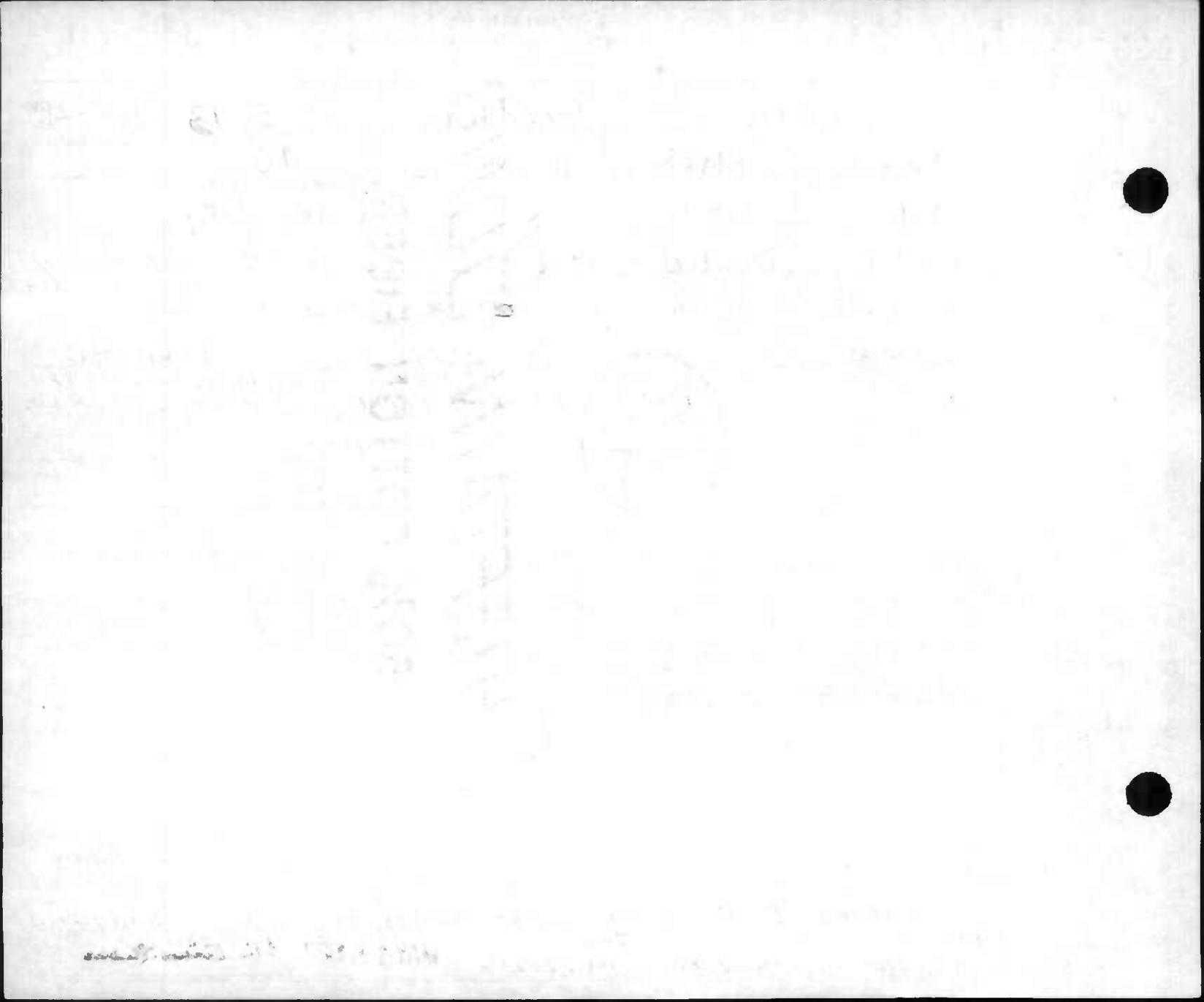
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hattie Goodman			2a. DATE OF DEATH MONTH DAY YEAR 5 13 87		2b. HOUR 542 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 05 96		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 90		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton South		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILY	
13a. STATE MARYLAND	13b. COUNTY BALTO.	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BALTO, MD, 21237		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES QUEEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN BRANFORD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.		16b. SOCIAL SECURITY NO. 218-22-7851		17. INFORMANT MRS. BALTIMORE, MD. 21237 MARTHA PRANN 2503 SOLOMONS ISLAND RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 19 86 to May 13 19 87 , that (I) (we) last saw the deceased alive on 4/13 19 87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE RUBEN REIDER MD.		DEGREE MD.		22c. DATE SIGNED MAY 15 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER MD.		22e. ADDRESS 7445 FURNACE BRANCH Rd GLEN BURNIE MD 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/19/1987	23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS 2501 GWYNNSFAULS PKWY. BALTO. MD. 21216			25a. DATE REC'D. BY REGISTRAR MAY 15 1987			
			25b. REGISTRAR'S SIGNATURE [Signature]			

BP



052446 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

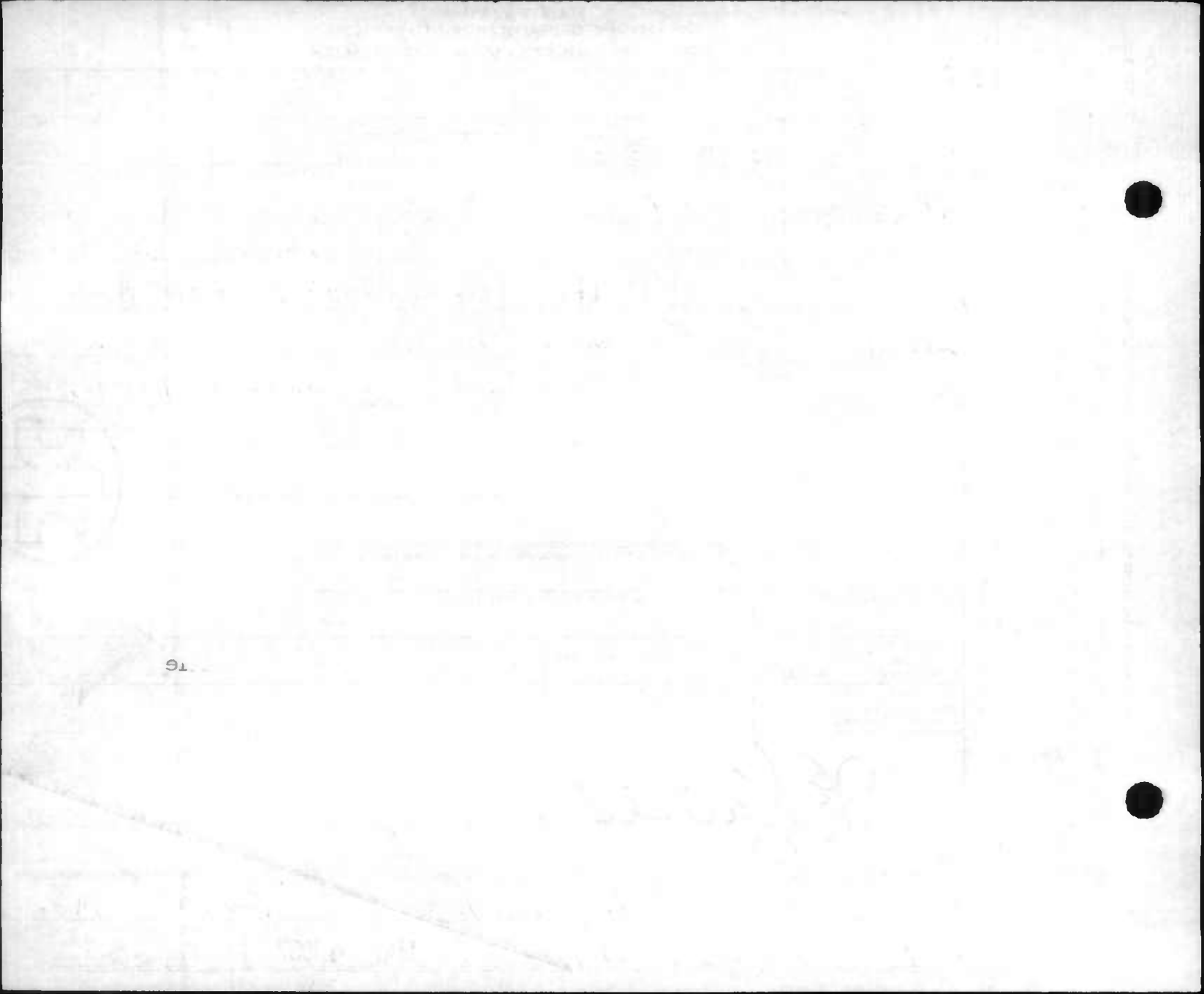
REG. NO. 13542

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)										DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		HOUR	
		FIRST JERRY		MIDDLE L.		LAST GOODMAN						<input checked="" type="checkbox"/> MONTH DAY YEAR		5-1-87 19		M	
3 SEX m		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 10 30 53		6 AGE (IN YEARS) LAST BIRTHDAY 33 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		5-1-87 19		10PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY mattress					
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2942 Arundel Ave.							
14. FATHER'S NAME FIRST MIDDLE LAST Leroy Goodman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Jackson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-58-2697				17. INFORMANT ADDRESS Lottie Goodman 2751 Riggs Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contact gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR PM MONTH DAY YEAR 5:28 5-1-87 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot self with 22 caliber rifle									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2942 Arundel Avenue Baltimore, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE John E. Smialek, M.D.				TITLE (SPECIFY) Chief				MEDICAL EXAMINER				DATE SIGNED 5-2-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (YES/NO) Burial				23b. DATE 5-6-87				23c. NAME OF CEMETERY OR CREMATORY King Man Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Carlton C. Dargatzis				ADDRESS 1701 McCulloch				25a. DATE REC'D. BY REGISTRAR MAY 4 1987				25b. REGISTRAR'S SIGNATURE Julia Gordon-Lindell					

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

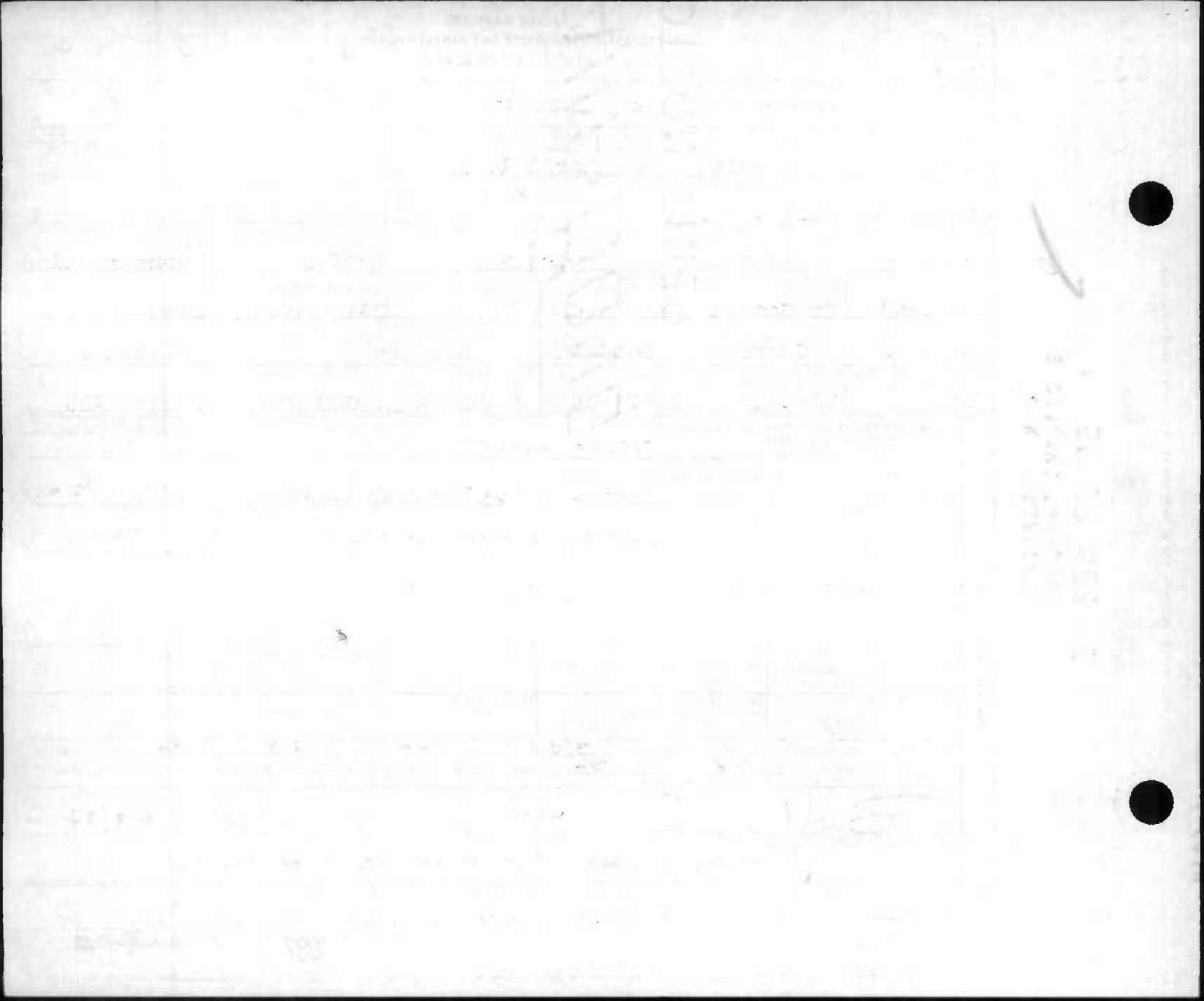
8713543

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P	
CHARLES EDWARD GOODWIN				MAY 8, 1987		4:25 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		April 1, 1953		34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Salem, New Jersey		USA				BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Roofer		construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Pr George		Suitland			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
Raymond Charles Goodwin		Lucille Fletcher		2313 Brooks Drive		20746	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		Vietnam		578-74-1919		JENNIFER L. GOODWIN Sameas #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF							5 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEPSIS - HEPATIC FAILURE</u>							50 days / 2 years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC ACUTE HEPATITIS</u>							2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HISTORY OF ALCOHOLISM & DRUG ABUSE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his) (her) attended the deceased from <u>3/24</u> 19 <u>87</u> , to <u>5/8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Brian J Ward</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Brian J Ward</u>				22e. ADDRESS <u>JOHNS HOPKINS - BALTIMORE</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11 May 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood PG Md</u>	
24. FUNERAL DIRECTOR NAME <u>Robert E Wilhelm</u>				ADDRESS <u>Suitland, Md.</u>		25. MAY 12 1987	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 4 4

REG. NO.

FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Morris Gorman		2a. DATE OF DEATH MONTH DAY YEAR April 19, 1987		2b. HOUR 2:10 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Philco Ford		12b. KIND OF BUSINESS OR INDUSTRY Automobile				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2918 Glenmore Avenue 21214		
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-09-6796		17. INFORMANT ADDRESS Mrs. Dorothy Simon 2609 Putty Hill Ave, 21234		
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>urinary retention 20 severe metastatic prostate CA benign prostatic hypertrophy unknown</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>It was obtunded and mentally incapable when admitted without a known medical history</u>								
		19a. DATE OF OPERATION 3/20/87, 3/31/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH, kistatutia urinary retention		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/22/1987</u> to <u>4/19/1987</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/19/1987</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> did not view the body after death.										
22b. SIGNATURE <u>Richard M. Gray, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>April 19, 1987</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. GRAY		22e. ADDRESS Union Memorial Hospital								
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Cremation		23b. DATE 04/22/1987		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR APR 20 1987		25. REGISTRAR'S SIGNATURE <u>Julia Borden-Rodale</u>						

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713545

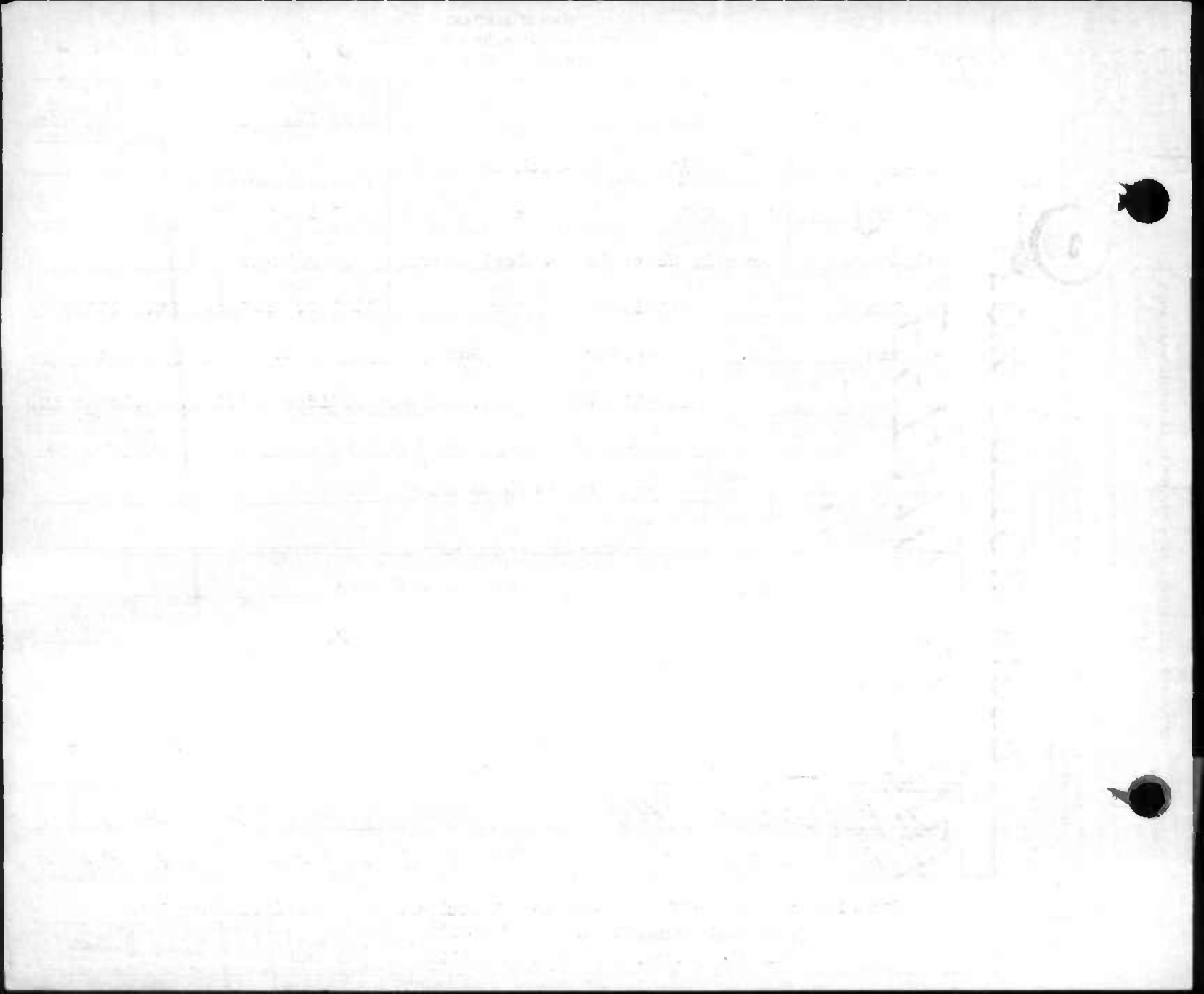
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Eula Mae Gower					May 17, 1987					1:45 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White	March 11, 1917		70		YRS		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Kentucky	USA			Baltimore City						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	Francis Scott Key Medical Center		Seamstress							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1101 S. Anglesea St. 21224		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST		FIRST MIDDLE LAST								
Acera C. Walker		Ada C. Stone								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		400-10-6704		Mrs. Barbara Redifer		1101 S. Anglesea St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <u>5/13</u> 19 <u>87</u> to <u>5/17</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/17</u> 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>AP Marco MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/17/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AP MARCO</u>		22e. ADDRESS <u>4940 EASTERN AVE BALTO.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Entombment		5-21-87		Oak Lawn Mausoleum		Baltimore Maryland				
24. FUNERAL DIRECTOR NAME		Duda-Ruck Funeral Home of Dundalk		25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE				
		7922 Wise, Ave. Dundalk, MD 21222		MAY 18 1987		<u>Julia Bender-Rudolph</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



055296 JUN 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13546

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROLAND A GOYNES		2a. DATE OF DEATH MONTH DAY YEAR 5 31 87 2b. HOUR 12:50 AM	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 13 - 09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CLIFFORD GAYNOS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FERGUSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218-07-1384	17. INFORMANT ADDRESS DONNA GOYNES 2805 W. MASON ST 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) TUBERCULOSIS DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/20 , 19 87 , to 5/31 , 19 87 , that (I) (we) last saw the deceased alive on 5-31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE ADRIAN M	DEGREE	22c. DATE SIGNED 5/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY C DIKE, MD	22e. ADDRESS LIBERTY MEDICAL CENTER BALTIMORE MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6-5-87	23c. NAME OF CEMETERY OR CREMATORY MD VETERANS	23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MD
24. FUNERAL DIRECTOR NAME ADDRESS Marshall P. Hayes 638 N. Gilman St	25a. DATE REC'D. BY REGISTRAR JUN 2 1987		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

054999 JUN 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13547
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STEPHEN GRACZKOWSKI			2a. DATE OF DEATH MONTH DAY YEAR 5 26 87		2b. HOUR 7:45 PM		
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 21 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCH RAVEN VA HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESS HELPER		12b. KIND OF BUSINESS OR INDUSTRY NATIONAL CAN	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JALOB GRACZKOWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE ZEKOSKI		13e. STREET ADDRESS / ZIP CODE 3031 ELLIOTT ST. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ANNA GRACZKOWSKI		ADDRESS 3031 ELLIOTT ST. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE SYSTEM FAILURE DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 3/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED unknown systemic process possible		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 7b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/29 , 19 87 , to 5/26 , 19 87 , that (I) (we) last saw the deceased alive on 5/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wahl LAENDER		DEGREE SP0129		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAHL LAENDER		22e. ADDRESS JOHNS HOPKINS UNIVERSITY					
23a. BURIAL, CREMATION, REMOVAL (50601) BURIAL		23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME LILLY & ZEILER, INC.		ADDRESS 1901 EASTERN AVE.		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Swickard-Randall	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a medical examiner.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 5 4 8

1- STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-30 1987										21. HOUR M 5:45P	
17. DECEASED NAME (TYPE OR PRINT) William L. Graham										22. DATE OF BIRTH MONTH DAY YEAR 07 28 65										23. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 07 28 65		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		24. DATE PRONOUNCED DEAD 5-30 1987		25. HOUR M 5:45P							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Op.				12b. KIND OF BUSINESS OR INDUSTRY Office Sup									
13a. STATE MD										13b. CITY OR TOWN Marriotsville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 950 Henryton Road							
14. FATHER'S NAME FIRST MIDDLE LAST William Arthur Graham					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Elizabeth Coop																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 218-98-2396					17. INFORMANT ADDRESS William A. Graham Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:15AM 5-30 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION CITY OR TOWN STATE 950 Henryton Rd., Baltimore City, MD													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-31-87													
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 06-02-87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION CITY OR TOWN STATE Baltimore MD											
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS 301 Frederick Road Catonsville, MD				25a. DATE REC'D. BY REGISTRAR JUN 2 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOTICE

W. J. W.



054127 MAY 1987

12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGE 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13549			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH ELIZABETH GRANT										2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 5-16-87										2b. HOUR 8:22P			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 23 1918		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 68 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-16-87										2d. HOUR 8:22P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City										MD	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1714 Poplar Grove Street								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALAD CHEF.				12b. KIND OF BUSINESS OR INDUSTRY PIMLICO HOTEL							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1714 POPLAR GROVE ST.		BALTIMORE, MARYLAND 21216													
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL BROWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVIA BELL GLOVER																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.					16b. SOCIAL SECURITY NO. 217-26-					17. INFORMANT MR. CLYDE GRANT					ADDRESS BALTIMORE, MD. 1714 POPLAR GROVE ST. 21216								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease and</u> <u>carcinoma of lung</u> (b) <u>carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5-17-87											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5/21/1987		23c. NAME OF CEMETERY OR CREMATORY MD NATIONAL MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL, MARYLAND													
24. FUNERAL HOME NAME 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216										25a. DATE REC'D BY REGISTRAR MAY 20 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Baker</i>									

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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1800 SYAM

054437 MAY 25 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

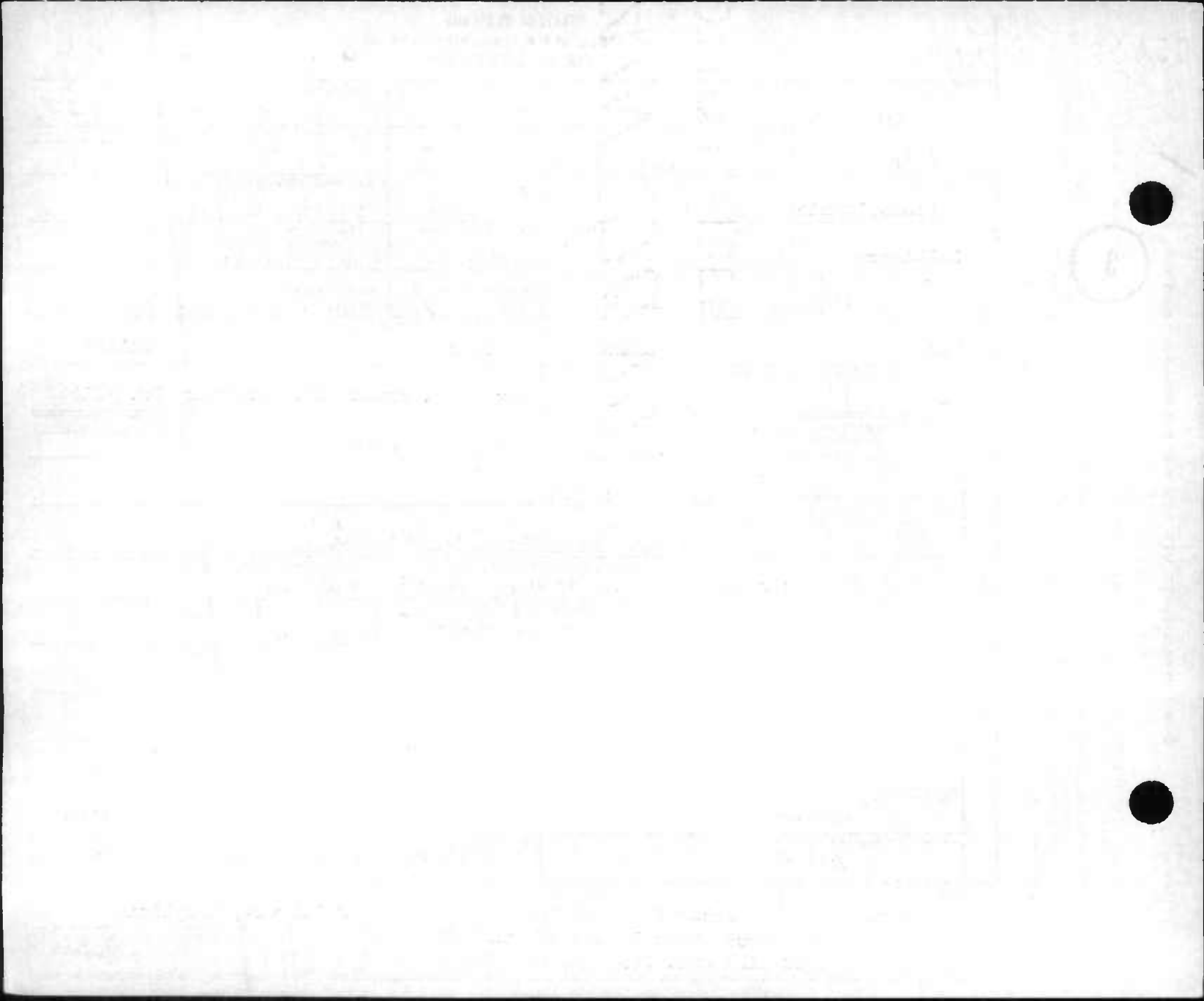
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13550

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George E Grant			2a. DATE OF DEATH MONTH DAY YEAR 5 19 87		2b. HOUR 950 M
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 13 16		6 AGE (IN YEARS LAST BIRTHDAY) 70	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Beth Steel		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FATHER'S NAME FIRST MIDDLE LAST Ned Grant		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Eckert		13e. STREET ADDRESS / ZIP CODE 7014 Mornington Rd 21222	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-10-0396		17. INFORMANT ADDRESS Ronald G. Grant 1938 Denbury Dr. 21222	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Graft Infection (axillofemoral)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive heart failure, renal failure, Diabetes mellitus					
19a. DATE OF OPERATION 5/18/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infection Axillofemoral graft		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/13 1987 to 5/19 1987 , that (I) (we) last saw the deceased alive on 5/19 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. Setya		DEGREE MD		22c. DATE SIGNED 5/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. Setya		22e. ADDRESS Dept of Surgery, FSK Medical Centre Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-87	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24 FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

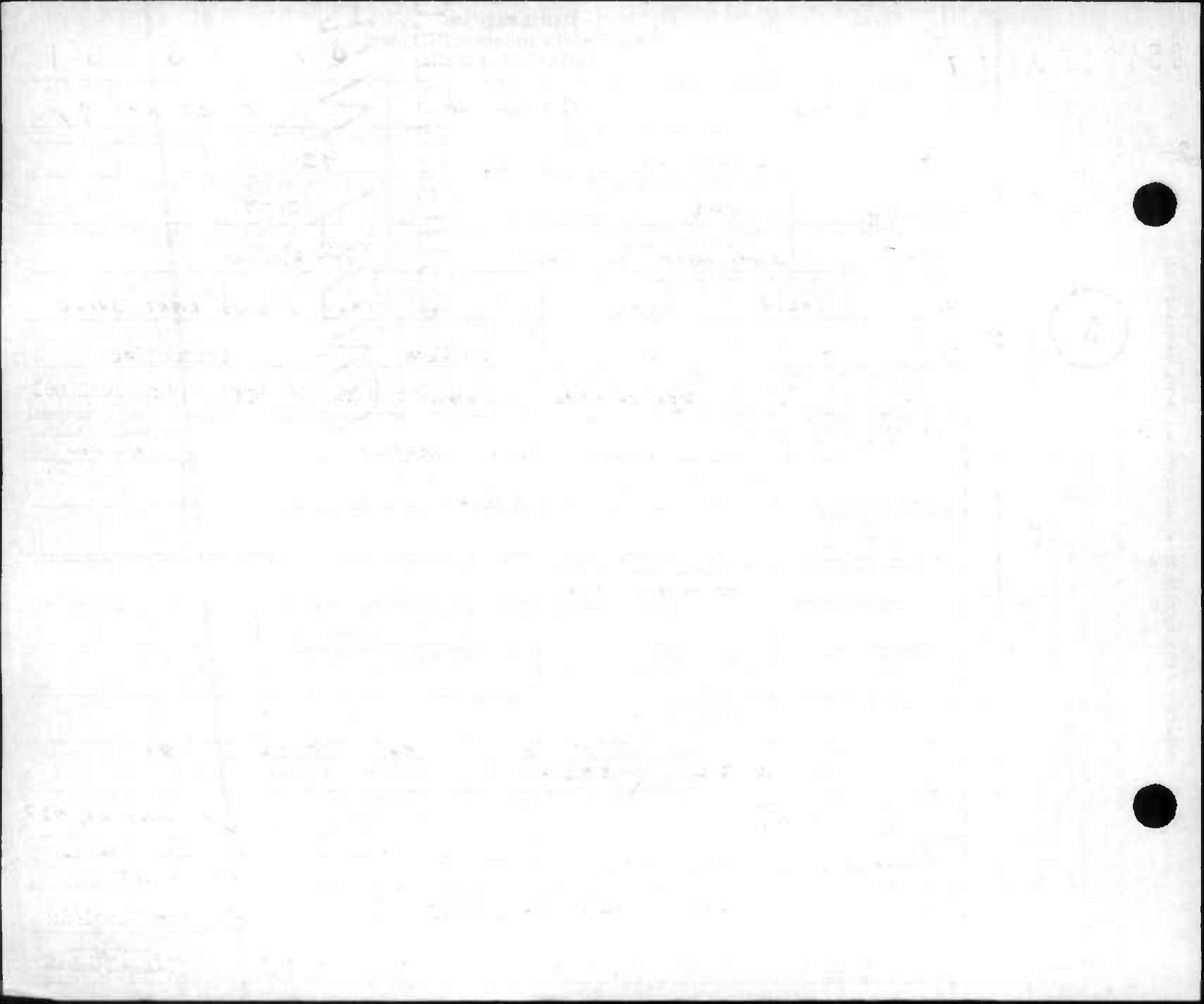
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713551
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Garda SOPHIA GRASHAM			2a. DATE OF DEATH MONTH DAY YEAR 5 22 87			2b. HOUR 9 P.M.				
3. SEX F		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 06 26 93		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				
10. CITY OR TOWN OF DEATH BALT.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP. OF BALT.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired NOT KNOWN		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY BALCO		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2228 SPRING LAKE DRIVE 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Olaf - Olsson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda - Larsdoffer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 056-26-51676	
17. INFORMANT Charles Grasham			ADDRESS 2228 SpringLakeDrive21093			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ADVANCED AGE</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> , 19 <u>87</u> , to <u>5-22</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5-22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>C. Pao</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED MAY 22, 1987				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. PAO M.D.			22e. ADDRESS SINAI HOSP, BELVEDERE AT GREENSPRING BALT, MD 21211.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/27/87		23c. NAME OF CEMETERY OR CREMATORY ArlingtonNational		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome 300MaceAve.21221						25a. DATE REC'D. BY REGISTRAR MAY 28 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall		

BP



054454

May 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13552

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD RUDOLPH GRAY			2a. DATE OF DEATH MONTH DAY YEAR 5 21 87			2b. HOUR 7-11 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 9 08		6. AGE (IN YEARS LAST BIRTHDAY) 78		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Paper Manuf.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1809 Wilson Point Rd. 21220		
14. FATHER'S NAME FIRST MIDDLE LAST Gray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Engeliter			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-05-8335	
17. INFORMANT ADDRESS Magdalen A. Gray 1809 Wilson Pt. Rd. 21220			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 HOURS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RHEUMATOID ARTHRITIS											
19a. DATE OF OPERATION --			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from MAY 5, 1987, to MAY 21, 1987, that (we) last saw the deceased alive on MAY 21, 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Loutfi Aboussouan						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED MAY 21 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUTFI ABOUSSOUAN						22e. ADDRESS GOOD SAMARITAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-23-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co., Md.				
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. 6224 Eastern Ave.						25. DATE REC'D BY REG. CLERK 25a. REGISTRAR'S SIGNATURE MAY 21 1987					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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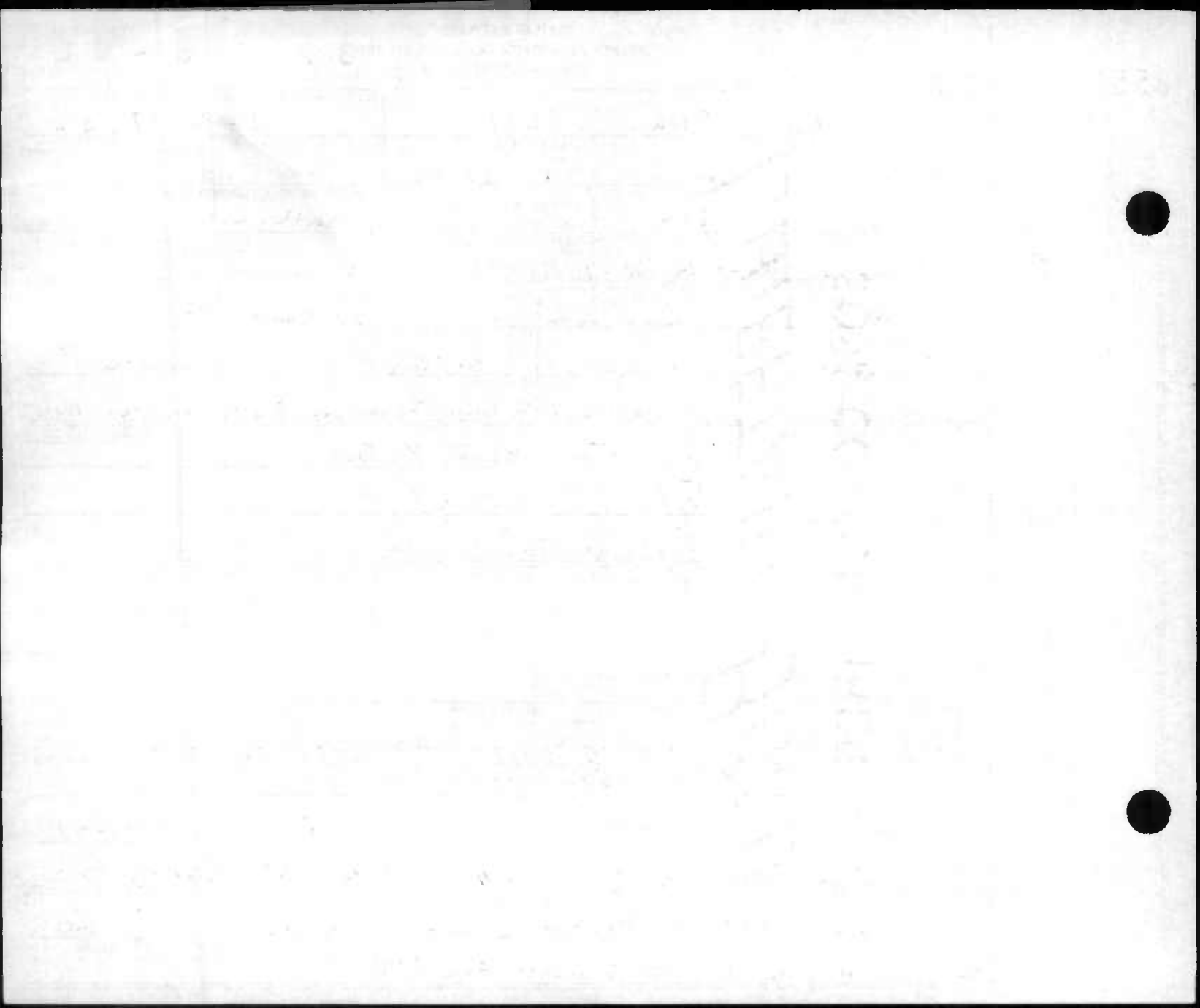
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 13553			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST May Etta GRAY										2a. DATE OF DEATH MONTH DAY YEAR 5-31-87		2b. HOUR 4:00 M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 29 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital & Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 611 Charles St. 21201					
14. FATHER'S NAME FIRST MIDDLE LAST Junious Gregory				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally White									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ND		16b. SOCIAL SECURITY NO. 219-28-1017		17. INFORMANT ADDRESS Vivian Johnson 2601 Madison Ave.									
18. CAUSE OF DEATH (Enter only one cause and the one for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypoproteinemias</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>5 May 1987</u> to <u>31 May 1987</u> , that (I) (we) last saw the deceased alive on <u>31 May 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE J.W. Reed M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/1/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. REED M.D.				22e. ADDRESS 611 S CHAS. ST BALTO MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD							
24. FUNERAL DIRECTOR NAME Wm. C. March E/H				ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR JUN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Deaton-Reed					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence J. Gredlein			2a. DATE OF DEATH MONTH DAY YEAR 05-28-87		2b. HOUR 5:38 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY Postal Serv./
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edward Gredlein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Vordron		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		
17. INFORMANT Mrs. Louise Gredlein		18a. SOCIAL SECURITY NO. 218-01-5265		18b. ADDRESS 4023 Lyndale Ave. 21213		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/28 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/28 , 19 87 , to 5/28 , 19 87 , that (I) (we) last saw the deceased alive on 5/28 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Brian H. Kohn, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian H. Kohn		22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-1-1987		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Joseph N. ZANNINO JR.		ADDRESS 2635 Conkling St. 21224		25a. DATE REC'D. BY REGISTRAR JUN 2 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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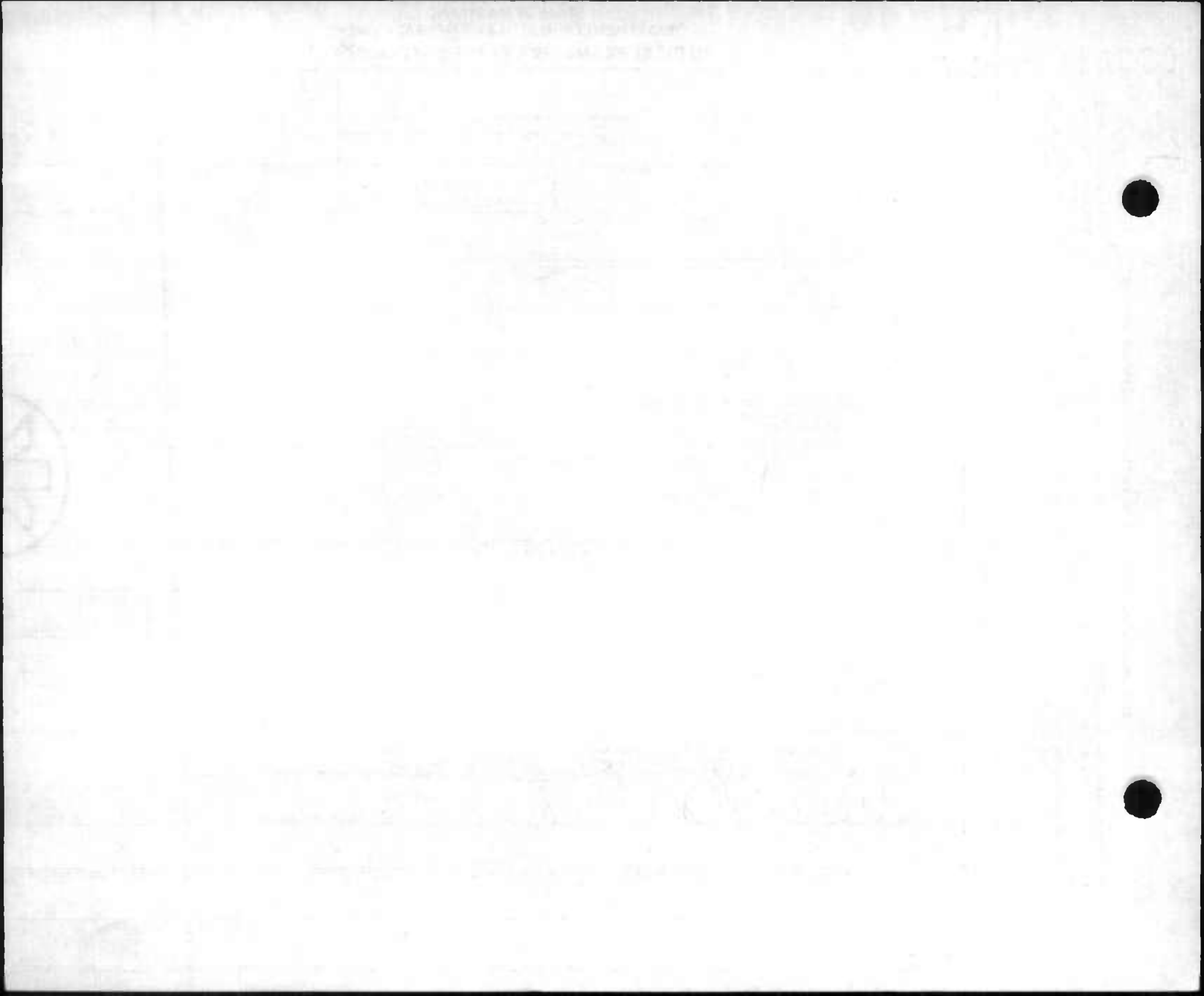
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

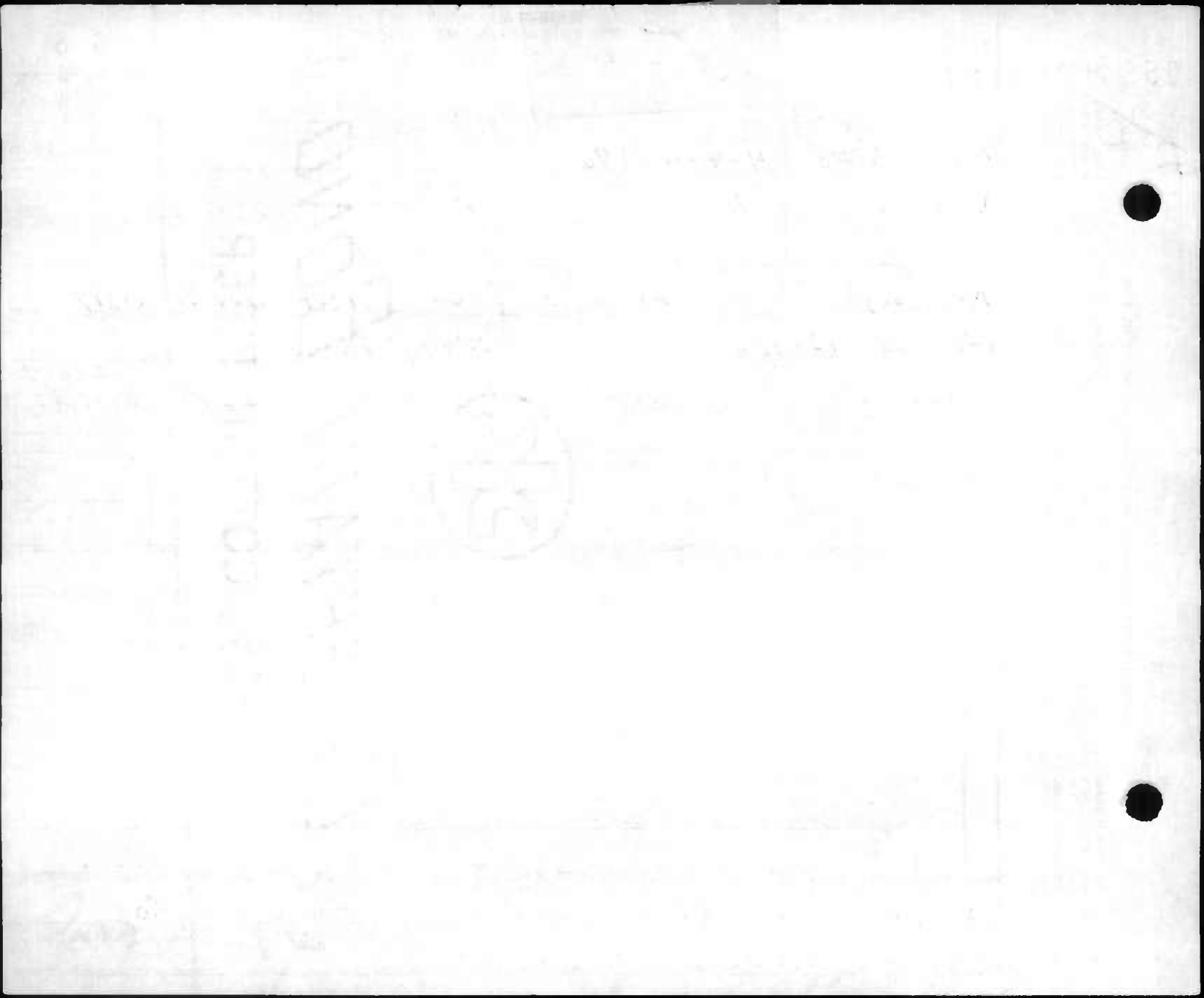
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13555	
1. DECEASED NAME (TYPE OR PRINT) Carrie E. Green										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5/ 24/ 19 87	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 9 19 1936		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/ 24/ 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital Shock Trauma			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21211 720 3700 Greenspring Avenue Apt			
14. FATHER'S NAME FIRST MIDDLE LAST H Jacie Spivey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margie Mitchell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-26-6930		17. INFORMANT ADDRESS Shirley Leazer 6019 Radecke Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:14pm 5/24/ 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject driver of auto/tractor trailer impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION CITY OR TOWN COUNTY STATE Rt. 70 & Rt. 32, W. Friendship, Howard Co., Md.					
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER DATE SIGNED 5/25/87			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/29/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			





054088 MAY 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13557

1. DECEASED NAME (TYPE OR PRINT) GARY Q GREEN										2a. DATE KNOWN OF DEATH ESTIMATED 5-16-87		2b. HOUR M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06-27-42		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-16-87		2d. HOUR 7:30P				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City								
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Business				12b. KIND OF BUSINESS OR INDUSTRY Computers				
13a. STATE Md.										13b. COUNTY A.A.		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 711 Oak Grove Cir. / 21146		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Green					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Hicks Harden													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 555-58-4926				17. INFORMANT ADDRESS Mrs. Rella Green (same as 13)										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I obesity																		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>										TITLE SPECIFY Assistant			MEDICAL EXAMINER			DATE SIGNED 5-17-87		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.										ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5-18-1987				23c. NAME OF CEMETERY OR CREMATORY Westview Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balt. Co. Md.						
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO										25a. DATE REC'D. BY REGISTRAR MAY 19 1987				25b. REGISTRAR'S SIGNATURE <i>John P. ...</i>				
ADDRESS SEVERNA PARK, MD. 21146																		

DIVISION OF VITAL RECORDS, 391 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCLOSURE ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 100-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 391 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completely. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
IDA		Female		Black		12 8 1900		86		S.C.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City		Baltimore		North Charles General		retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																	
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11 W 20th St																	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																							
Charlie		Emma																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																			
NO		247-26-6808		Audrey McCallum		3314 Woodrope																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																									
PART I. DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) PNEUMONIA & RESPIRATORY FAILURE																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																									
(b) HYPOALBUMINEMIA																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c) ANEMIA																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED																					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2																					
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19																							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION																					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE															
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																									
22a. I certify that (I) (this hospital) attended the deceased from 5/27 87, to 5/27 87, that (I) (we) lost																									
saw the deceased alive on 5/27 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated																									
above, (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED																			
A. C. Chouvalit, M.D.						5/27/87																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																							
A. C. CHOUVALIT, M.D.		NORTH CHARLES GEN. HOSP.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																			
Burial		6/2/87		Arbutus Mem Park		Arbutus																			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																					
NAME		ADDRESS																							
Wm. C. March F/H West		6-1-87																							
4300 Wabash Avenue																									

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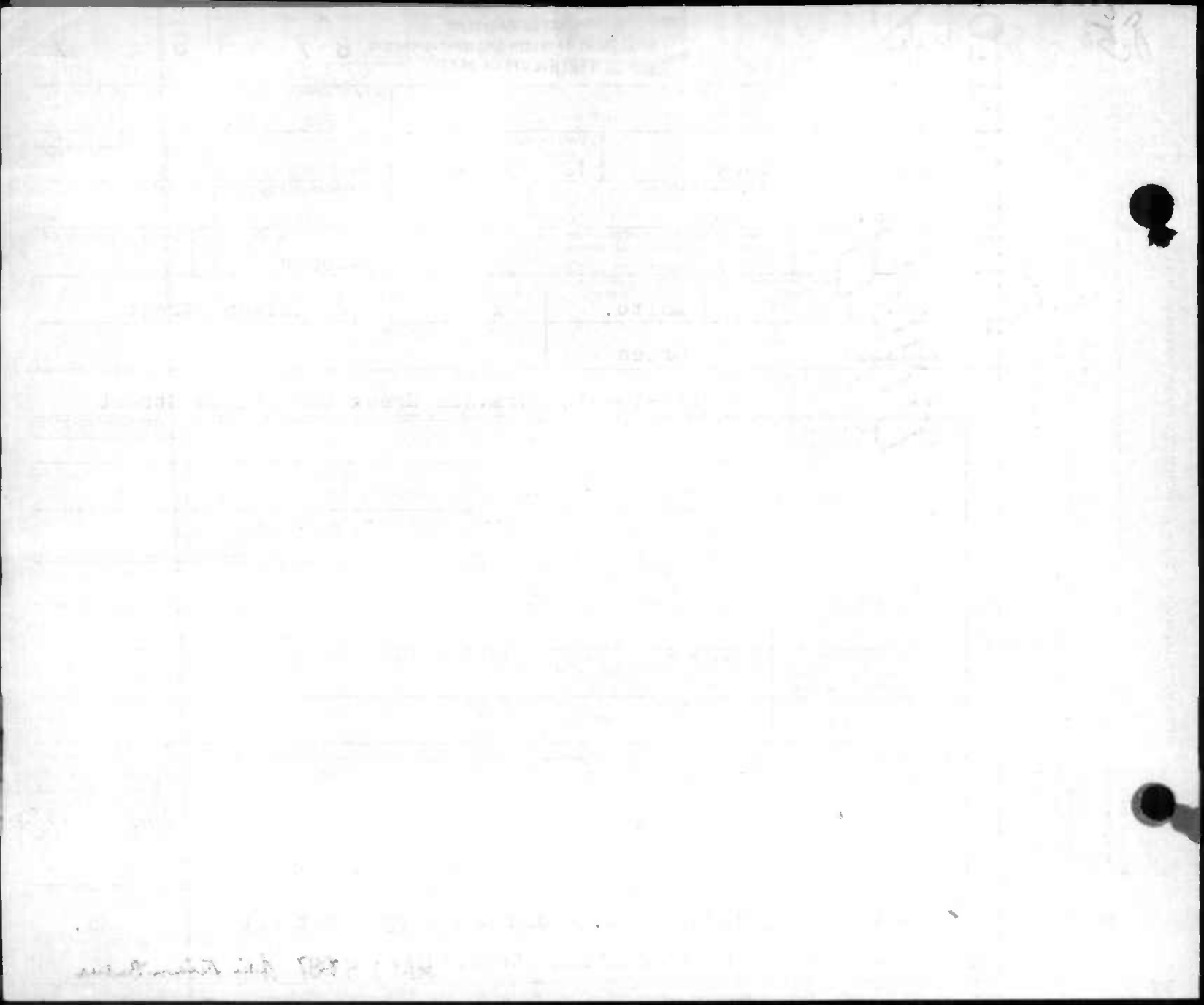
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner (not hospitalized at death).

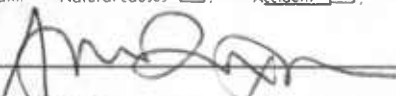

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Melvin Green						2a. DATE OF DEATH MONTH DAY YEAR May 9, 1987				2b. HOUR 10:40am	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 25 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 402 Wilson Street 21217			
14. FATHER'S NAME FIRST MIDDLE LAST William Green				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 210-10-8141		17. INFORMANT ADDRESS Mrs. Ada Green 402 Wilson Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis-Urosepsis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostatic Cancer											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Obstructive Uropathy and Chronic Renal Failure											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Obstructive Uropathy, Cardiac Arrhythmias, Anemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from May 8, 19 87 , to May 9, 19 87 , that (I)(we) last saw the deceased alive on May 9, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Huang				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED May 11, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Huang M.D.				22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westport Md.					
24. FUNERAL DIRECTOR NAME Chatman-Harris FM 1701 McCulloh Street						25a. DATE REC'D. BY REGISTRAR MAY 15 1987		25b. REGISTRAR'S SIGNATURE Julia Benbow-Parker			



155544 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13560			
1. DECEASED NAME (TYPE OR PRINT) GEORGE Mc Daniel GREENE										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 25 19 87		2b. HOUR AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4-9-1928		6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.		IF UNDER 24 HRS. MONTHS DAY HRS. MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 25 19 87		2d. HOUR 9:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY U.S. Mail	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS 405 Wellham Ave., 21061			
14. FATHER'S NAME FIRST MIDDLE LAST Early E. Greene						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 230-28-0143		17. INFORMANT ADDRESS Martha Y. Greene, Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7 8120 IMMEDIATE CAUSE (a) Closed head injury with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic heart valvular disease													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 7:54 P.M. 5-7- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of pick-up truck/auto collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Wellham Ave. Anne Arundel MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 5-26-87					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-30-1987		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR MAY 28 1987				25b. REGISTRAR'S SIGNATURE 			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 6 1

FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE F. A. GREENE SR.			2a. DATE OF DEATH MONTH DAY YEAR MAY 26, 1987		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 22 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Green		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-09-5690		17. INFORMANT ADDRESS Willie A. Greene, Sr. 1700 Eutaw Pl.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>END STAGE RENAL DISEASE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>87</u> , to <u>5/26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE <i>Paul Hoetner</i>		DEGREE MD		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL HOETNER		22e. ADDRESS UNION MEMORIAL HOSPITAL BALTIMORE, MD 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus	
23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.		24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home 1101 E. North Ave.			
25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i>			

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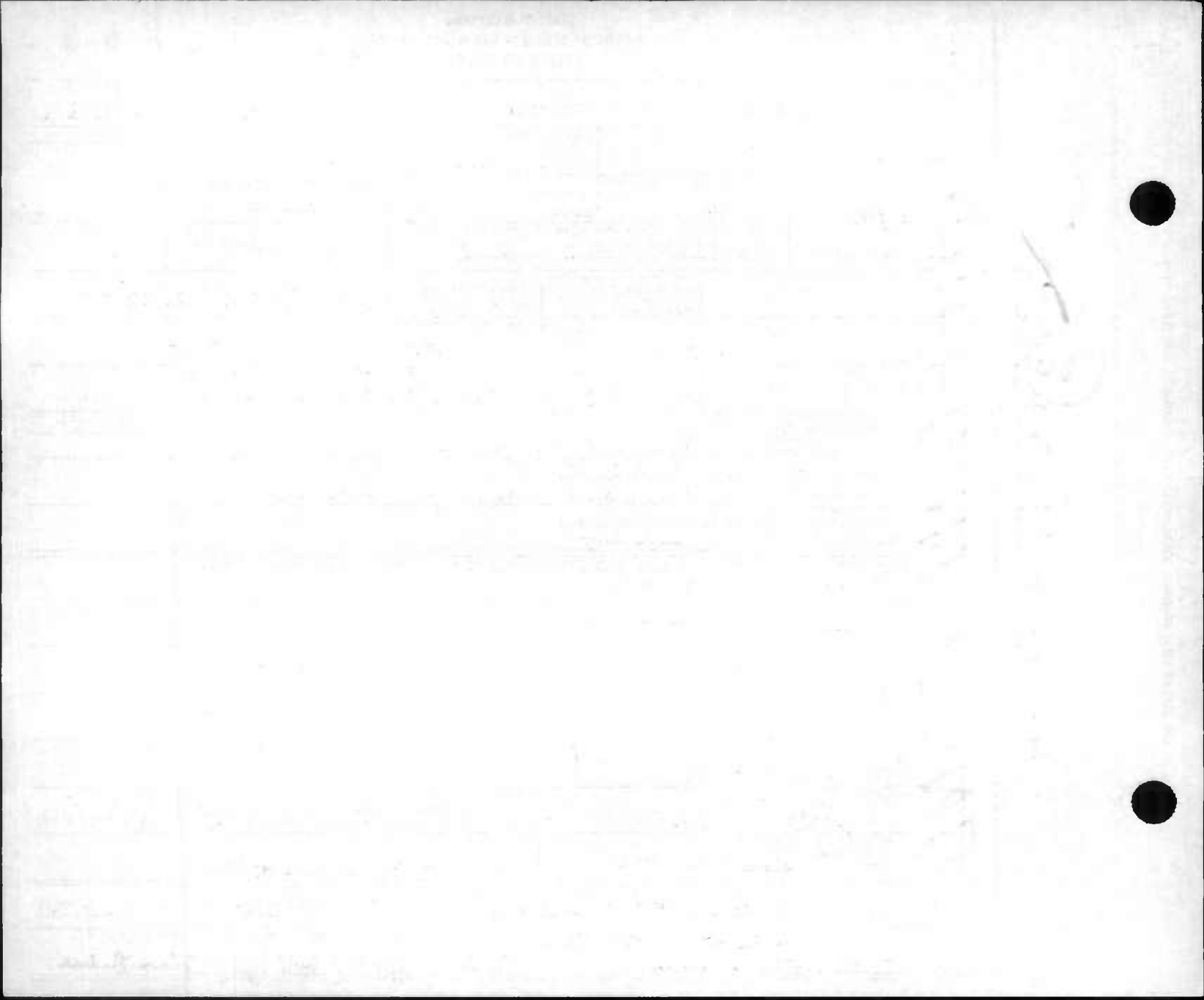
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages from page 2 and 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked for item 18, a copy of item 18 should be filed with the funeral home and be notated on page 4.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isidor H. Gresser					2a. DATE OF DEATH MONTH DAY YEAR 5 22 87		2b. HOUR 0930 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 3, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST		12b. KIND OF BUSINESS OR INDUSTRY DRUG			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS GRESSER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE FELDMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-09-2219		17. INFORMANT MRS. HELEN GRESSER			APT. 501 3601 FORDS LA. BALTO., MD 21215				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ISCHEMIC CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/22 1987 to 5/22 1987 , that (I) (we) last saw the deceased alive on 5/22 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S.O. Trerotola MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.O. Trerotola MD						22e. ADDRESS The Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 24, 1987		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC.						25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Sol Levinson-Randner			
6010 REISTERSTOWN RD. BALTO., MD 21215											

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

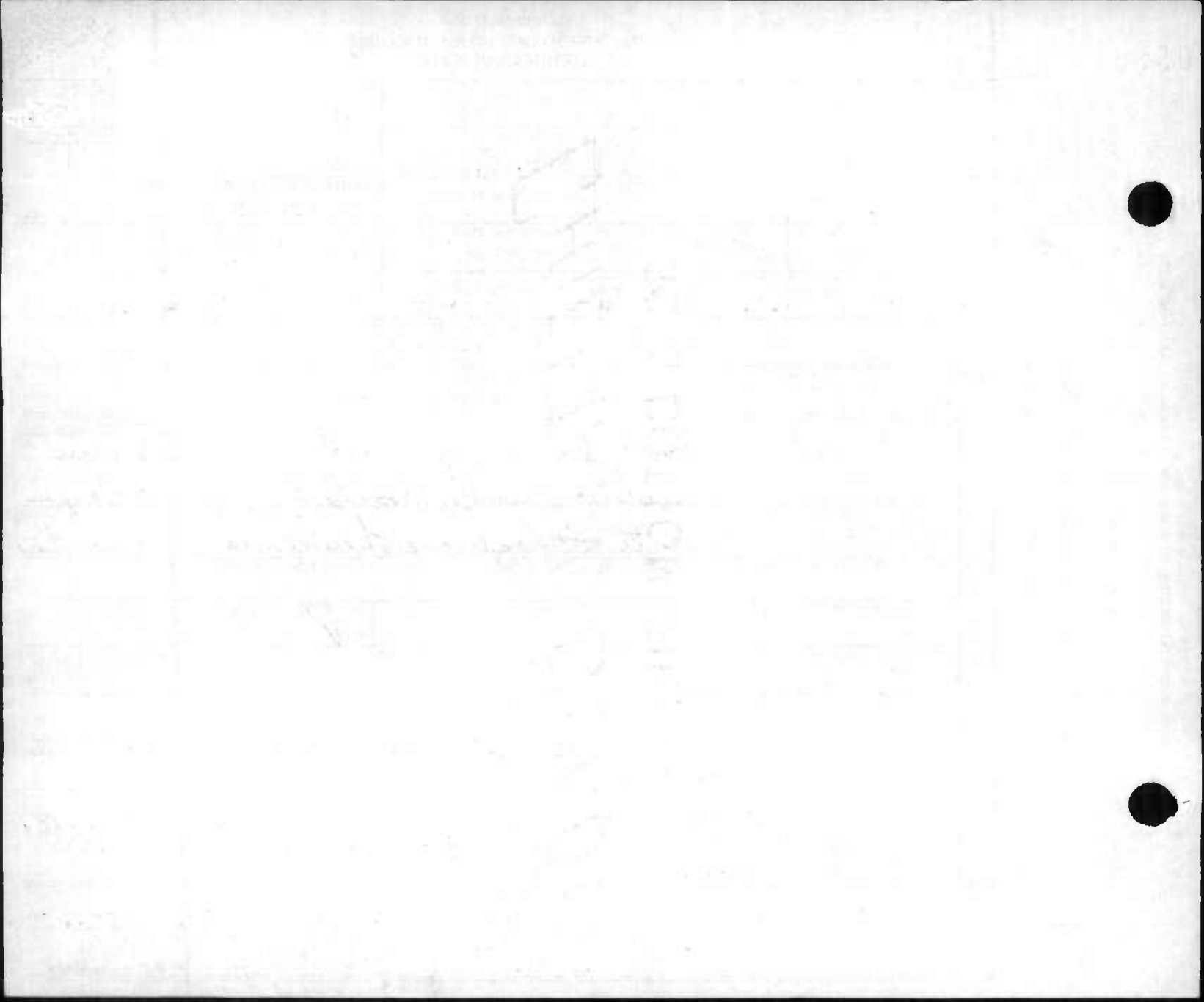
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
EMILY Mary GROSH					MAY	27	1987		12:55pm
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White		Mar. 7, 1927		60 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.	USA				BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		JOHNS HOPKINS HOSPITAL			Receptionist		Clerical		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13e. STREET ADDRESS / ZIP CODE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	806 Glenview Ave., 21061				
Maryland		A.A.		Glen Burnie					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Frank		Mewshaw		Loretta Klug					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no		216-22-2505		Melvin Grosh Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>									5 min
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u>									10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Acute Myelogenous Leukemia</u>									2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> , 19 <u>87</u> , to <u>5/27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Joseph M. Sutton MD</u>								<u>5/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
JOSEPH M. SUTTON MD				600 N WOLFE ST BALTO 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		5/30/87		Glen Haven Mem Pk.		Glen Burnie, AA Co., Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		JUN 1 1987		Julia Swanson-Randall					
McCully Funeral Homes Balto., Md. 21225									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



055034 JUN 1

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

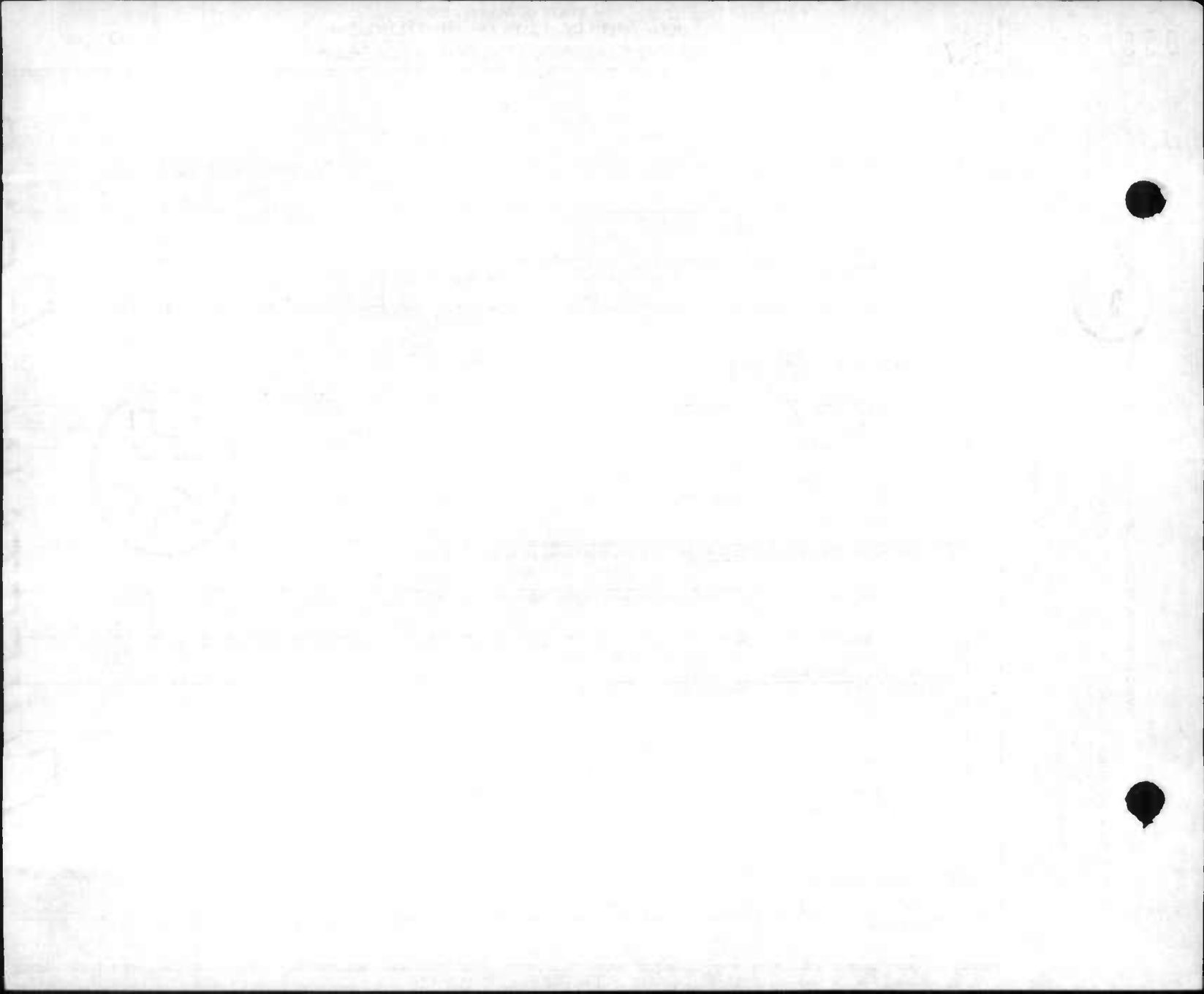
REG. NO. 13564

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Alphonso			Guarte			5/ 24/19 87		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
male	black.	1 13 1937	50 YRS.			5/ 24/19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md	U S A					Baltimore City, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			Maryland General Hospital			Disabled		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md						Baltimore		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Calixto			Guarte			Amanda		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			17b. SOCIAL SECURITY NO.			17c. INFORMANT ADDRESS		
Yes			213-32-0730			Myrtle Boone 236 N. Hilton Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
<i>Dennis F. Smyth</i>			Assistant			5/25/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			6/1/87			Garrison Forest Vet		
23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Owings Mills						Md		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		
Wm. C. March F/H			West 4300 Wabash Avenue			JUN 1 1987		
						25b. REGISTRAR'S SIGNATURE		

07/84
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(VR A15 ME (5))

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 13565	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MARY		GANTHER GUNTHER		5 124 187	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
F	W	11 01 1907		79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		STAGNES Hosp. Bal		Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		STAGNES Hosp. Bal		Sales	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Balto.		Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Raymond		Kirby		Lillian Stark	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>	
212-14-8621		Ms. Esther Beutelspacher		131 Maple Ave. 21228	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Edmund P. Tkaczuk		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
EDMUND P. TKACZUK					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		5-25-87			
24. FUNERAL DIRECTOR NAME		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
State Anatomy Board		Balto., Md.		MAY 28 1987	
23f. REGISTRAR'S SIGNATURE		23g. REGISTRAR'S SIGNATURE			
		Julia Swenson-Randall			

Handwritten notes and scribbles at the top of the page, including the word "ON" and some illegible markings.

Handwritten notes and scribbles in the middle of the page, including the word "ON" and some illegible markings.

Handwritten notes and scribbles at the bottom of the page, including the word "ON" and some illegible markings.

055090 JUN - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked, item 18 should only injury, or other traumatic event, the medical examiner must be notified.

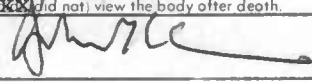
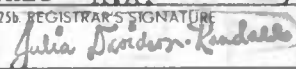
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(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 13500

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE L. GULDEN			2a. DATE OF DEATH MONTH DAY YEAR 05 26 1987		2b. HOUR M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 05 12 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VILLA ST. MICHAEL NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE OPERATOR	
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLICOTT CITY	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC M. LAWRENCE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE G. WIGGINS		17. ADDRESS 2614 Melba Rd. Ellicott City 21043	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-12-3619		17. INFORMANT WALTER LAWREN CE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (XXXX) attended the deceased from 9 JANUARY 1986 to 26 MAY 1987 , that xx (we) last saw the deceased alive on 26 MAY 1987 , and that in (my) (xx) opinion death occurred on the date and hour and from the causes stated above, (I) (XXXX) did not view the body after death.					
22b. SIGNATURE 		DEGREE MD		22c. DATE SIGNED 26 MAY 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR M. LEBSON, M.D.		22e. ADDRESS 3640 FORDS LANE BALTO 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/28/87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk. Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME HARRY H. WITZKE & FUNERAL HOME, INC.		ADDRESS 4112 Columbia Rd. Ellicott City, Md., 21043		25a. DATE REC'D. BY REGISTRAR JUN 1 1987	
				25b. REGISTRAR'S SIGNATURE 	

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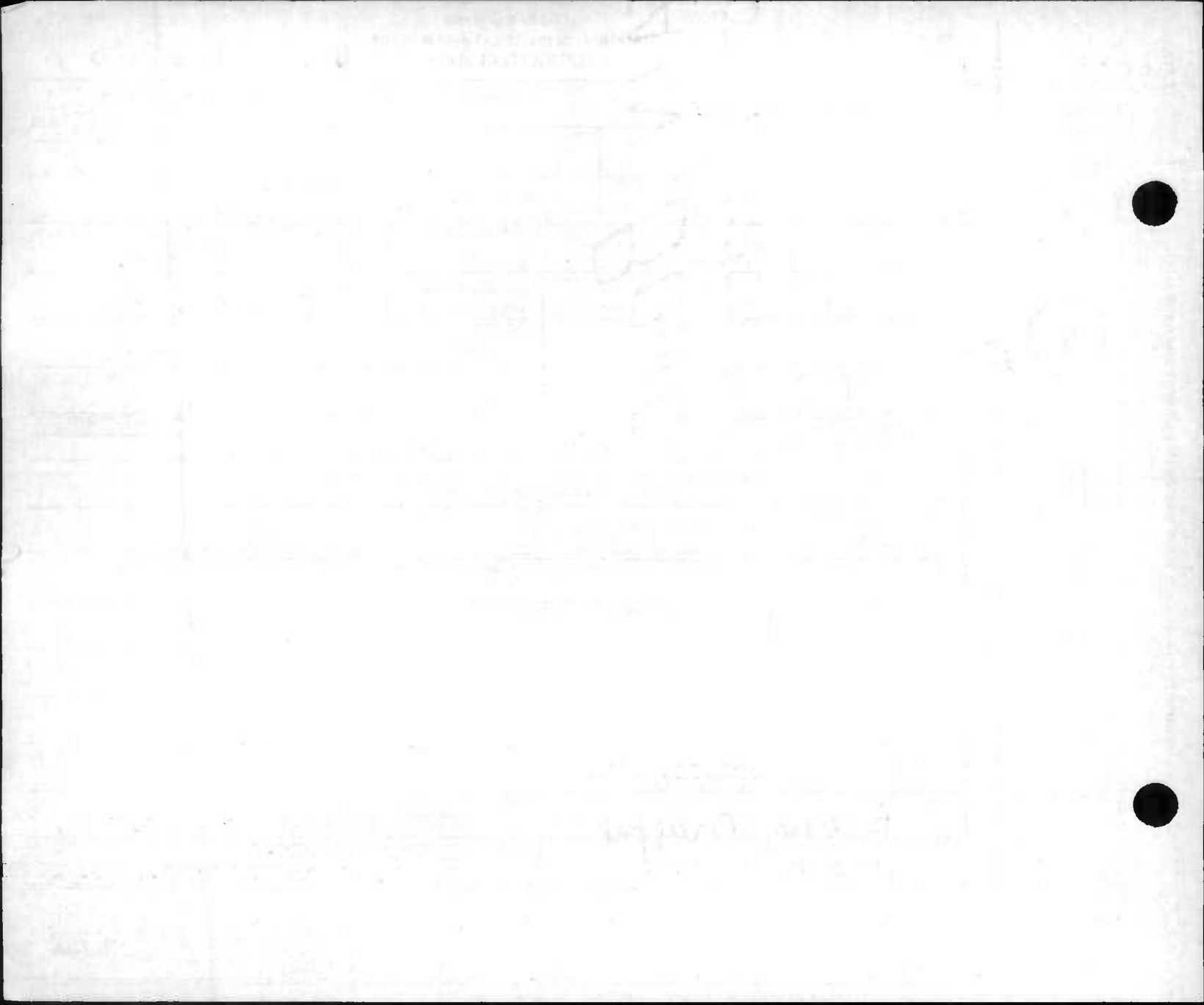
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8713567
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LOUIS J. HAJEK				MAY 19, 1987		2:20p _M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	Cauc.	11 27 1911		75 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Md.	U.S.A.			Baltimore City MD.		Govt.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Baltimore	Church Hospital		Corker				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
Md.			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	131 S. Curley St. 21224		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS			
Joseph Hajek		Mary Marker		Sadie Hajek 131 S. Curley St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WW II		212-05-7596A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CANCER OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 18</u> , 19 <u>87</u> , to <u>MAY 19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MAY 19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Beena Nagpal						MAY 19, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
BEENA NAGPAL, M.D.		CHURCH HOSPITAL 100 N. BROADWAY/BALTO., MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation	5/22/87	Greenmount Cem.		Baltimore MD.			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B. Dabrowski & son 2818 E. Baltimore St.		MAY 26 1987		Julia Dabrowski-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



054558 MAY 27 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8713568

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Neil D. Haldeman II			2a. DATE OF DEATH MONTH DAY YEAR 5 15 87		2b. HOUR 4P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 12 55		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MALE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MATH TEACHER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE DEL		13b. COUNTY SUSSEX	13c. CITY OR TOWN SEAFORD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST 3 NEAL D. Haldeman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOAN KOZAK		13e. STREET ADDRESS / ZIP CODE 412 HICKORY LA 19973	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 155-36-1449		17. INFORMANT ADDRESS BONNIE HALDEMAN 412 HICKORY LA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/4/87, 19 87, to 5/15, 19 87, that (I) (we) lost saw the deceased alive on 5/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Deborah Ann Whitehead MD		DEGREE MD	22c. DATE SIGNED 5/15/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah Ann Whitehead		22e. ADDRESS F.S.K. Hospital Eastern Ave Baltimore	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/21/87	23c. NAME OF CEMETERY OR CREMATORY WICOMICO MED PARK	23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY MD.
24. FUNERAL DIRECTOR NAME B. DABROWSKI		25a. DATE REC'D. BY REGISTRAR MAY 26 1987	
25b. REGISTRAR'S SIGNATURE Anita Davison-Randall			

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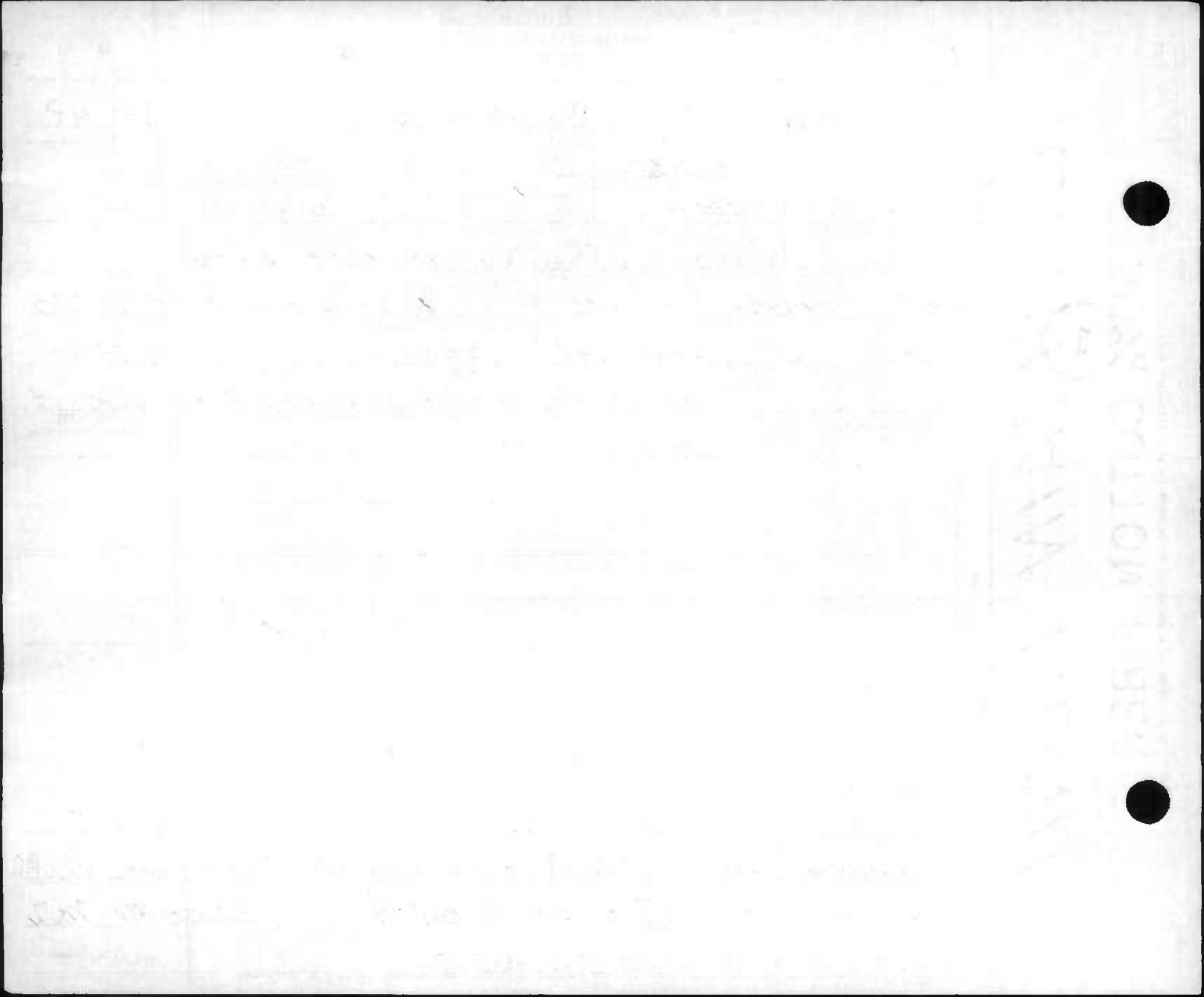
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8713569	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		May 30, 1987		M	
Yvonne		Lynn		Hale							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR Sept 10 1974		12 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Baltimore City				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		1609 Filbert Street (Home)		Student		School					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1609 Filbert Street 21226			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Jerry R. Hale		FIRST MIDDLE LAST Charlotte I. Parker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		=====		Jerry R. Hale		Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1) Hypoxemia (Probable)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Upper Airway obstruction</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Obstructive sleep Apnea</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Upper Respiratory Infection</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>5) Excess Weight</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
		Home		7/10/86		5/27 87					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/27 87</u> to <u>5/27 87</u> , that (I) (we) last saw the deceased alive on <u>5/27 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Colvin C. Carter MD				6/1/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Colvin C. Carter MD		4710 Pennington Ave Baltimore									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/2/87		Glen Haven Mem Park		Glen Burnie A.A. Md					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George J. Gonce 4001 Ritchie Hwy Balto Md				JUN 2 1987		Julia Gordon-Rodgers					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

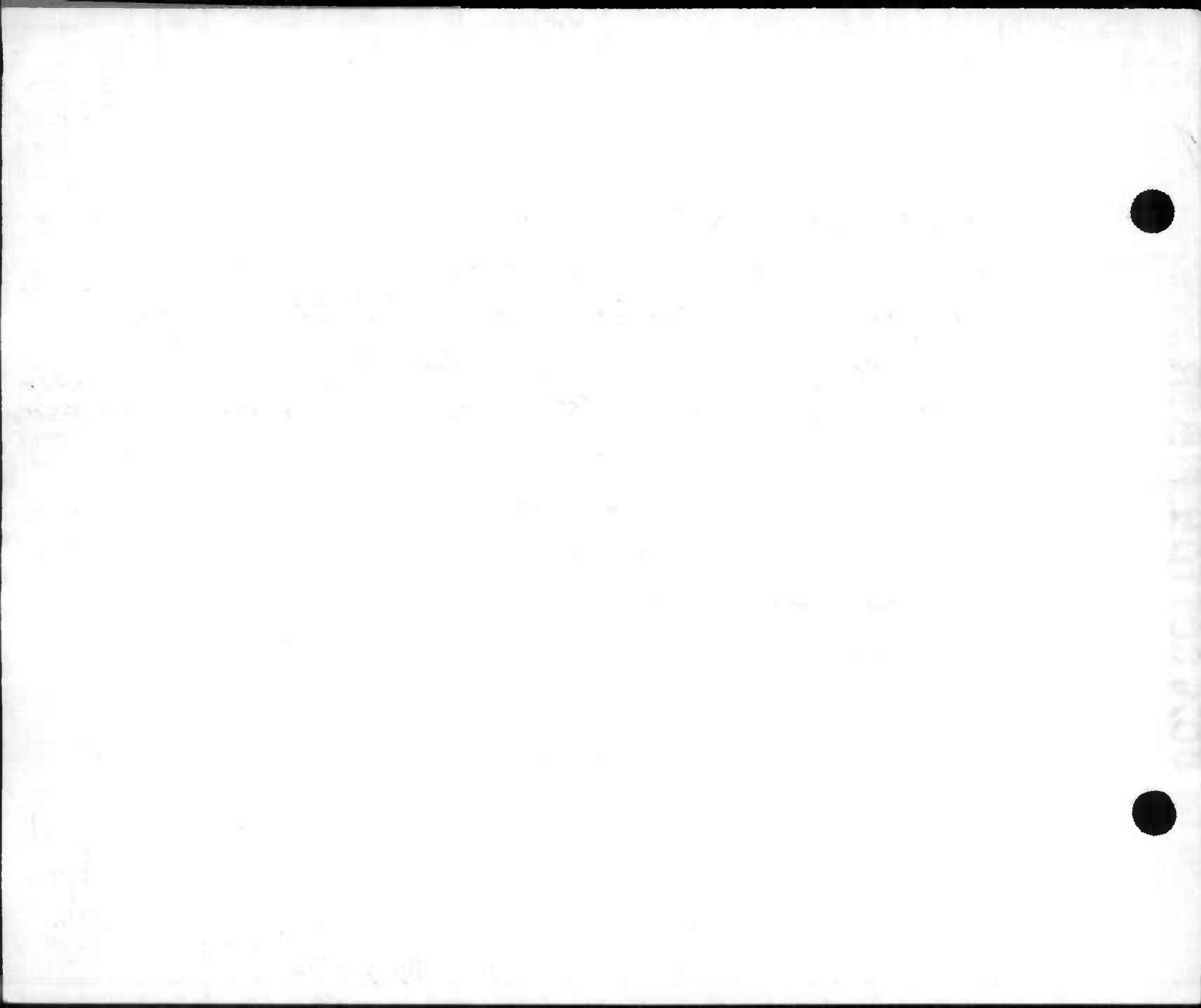
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13570

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Hall			2a. DATE OF DEATH MONTH DAY YEAR May 31, 1987			2b. HOUR 7:26 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY BALTO.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME George M. Cee			15. MOTHER'S MAIDEN NAME Katie		16. STREET ADDRESS / ZIP CODE 1633 Moreland Ave. 21216				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-01-1883		17. INFORMANT Mrs. Alfred A. Hall Parker 21216				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis, Upper GI 4 days DUE TO, OR AS A CONSEQUENCE OF (c) Infected Decubitus Ulcers 6 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) S/P CVA; De mentia; Upper GI Bleed									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 11 May 1987 to 31 May 1987, that (I) (we) last saw the deceased alive on 31 May 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David Jung						DEGREE M.D.		22c. DATE SIGNED 31 May 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Jung						22e. ADDRESS Liberty Med Center 900 Liberty Hts			
23a. BURIAL, CREMATION, REMOVAL (SPEIFY) Burial			23b. DATE 6-6-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE H.A. Co. Md.		
24. FUNERAL DIRECTOR NAME Russ F/H						ADDRESS 2222 W. North Ave		25. DATE REC'D. BY REGISTRAR JUN 3 1987	
						26. REGISTRAR'S SIGNATURE Julia Jordan-Ruders			



055350 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2b. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		THELMA MAGDALINE HALL		Female		White		June 14 th 1904 ^{AD}		82		Maryland		USA				BALTIMORE CITY MD		5 31 87		5:45a M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
BALTIMORE		BELAIR CONVALESCARIUM		Retired- Bugatch				Md.		Balto.		Dundalk				1715 Watervale Rd. 21222							
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS													
Jefferson		MaryJane Clinton		no		214-30-5098		Thelma Kessler		1715 Watervale Rd. 21222													
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.V.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTERIOSCLEROTIC CARDIO-</u> <u>VASCULAR DISEASE</u>																					
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AS HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION (STREET CITY OR TOWN COUNTY STATE)																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> <u>19</u> <u>87</u> to <u>5/30</u> <u>19</u> <u>87</u> that (I) (we) last saw the deceased alive on <u>5/30</u> <u>19</u> <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death)		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED															
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Luis E. Rivera		6/1/87		5714 HARFORD RD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)																	
Cremation		6/1/87		Security Process Inc.		Baltimore Maryland																	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
ConnellyFuneralHome		300MaceAve. 21221				JUN 2 1987		Jia Davidson-Rodgers															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

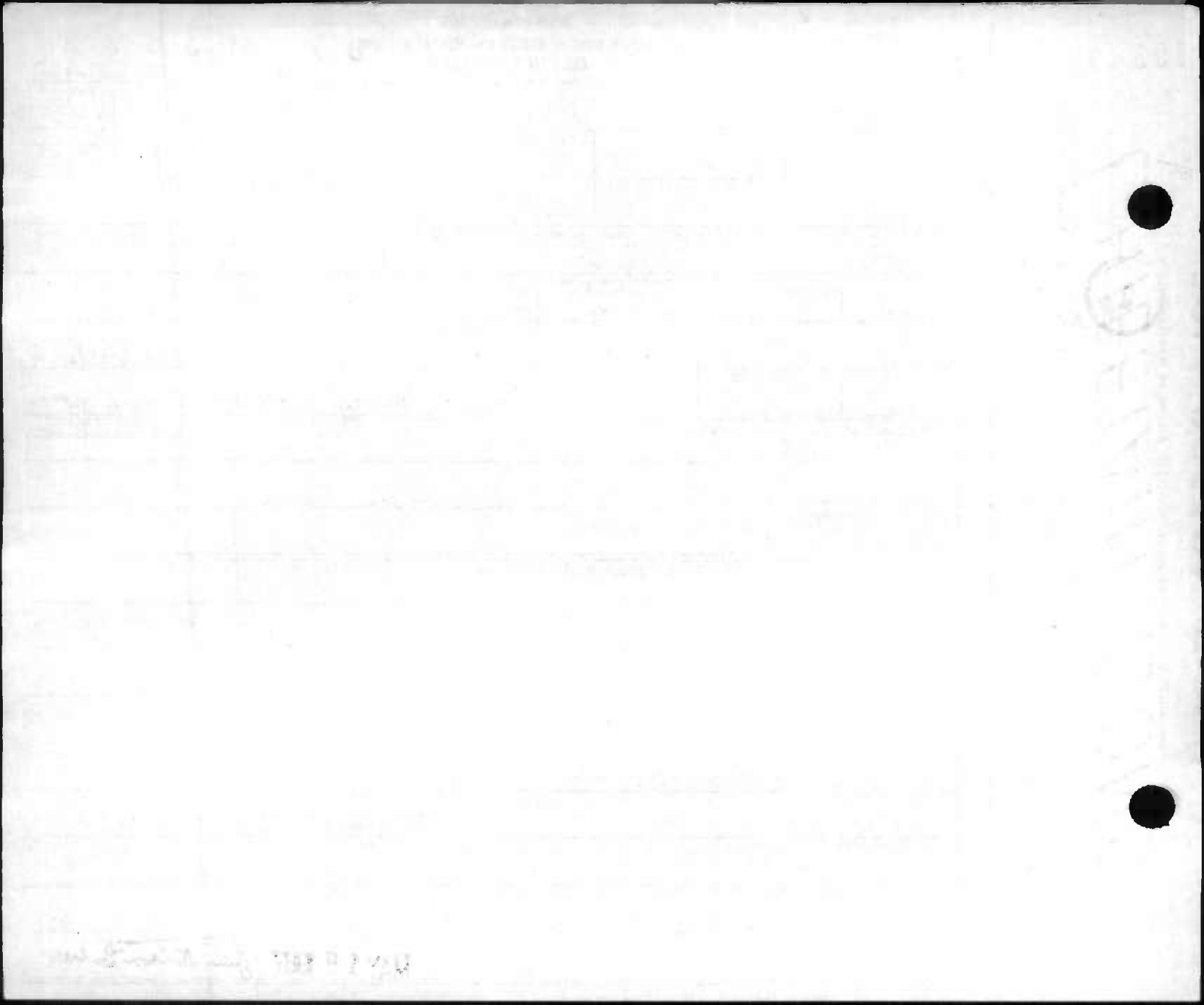
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST HUBERT	MIDDLE J.	LAST HALLEY	2a. DATE OF DEATH MONTH DAY YEAR 5-14-87	2b. HOUR 4:10am M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 8 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD.				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hn of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1410 W. Mosher St 21217				
14. FATHER'S NAME FIRST MIDDLE LAST Burrell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah B. Reynolds		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 218-12-8368		17. INFORMANT ADDRESS Dessie Halley 1410 W. Mosher St						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinomatosis (diffuse metastatic cancer)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a. DATE OF OPERATION φ		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED φ		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. φ 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) φ				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) φ		21f. LOCATION STREET CITY OR TOWN COUNTY STATE φ				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>87</u> , to <u>5-14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5-13 11:30am</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE V. Mossman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-14-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. MOSSMAN				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/18/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co Md		
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP



052538 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 7 3

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN J. HALLOWELL			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1987		2b. HOUR 130^A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7, 1928		
6. AGE (IN YEARS LAST BIRTHDAY) 59		7. BIRTHPLACE (STATE OR FOREIGN) Darby, Pa.		8. CITIZEN OF WHAT COUNTRY? U. S. A.		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1020 S. Charles Street		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Engineer- Army		12b. KIND OF BUSINESS OR INDUSTRY U.S.		13. STREET ADDRESS / ZIP CODE 1020 S. Charles St. 21230.		
14. FATHER'S NAME FIRST MIDDLE LAST Harry N. Hallowell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia --- Donahy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
17. SOCIAL SECURITY NO. 181-22-3204		18. INFORMANT Wife: Mary D. Hallowell		19. ADDRESS P.O. Box 13262; Baltimore, Md. 21203		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 4 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that: (1) (this hospital) attended the deceased from 1-85 , 19 85 , to 5-2 , 19 87 , that (1) (we) lost saw the deceased alive on about 4-4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.						
22b. SIGNATURE B Barbara A. Conley MD		DEGREE MD		22c. DATE SIGNED 5-4-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA A. CONLEY MD		22e. ADDRESS UMCC 22 S. Greene St Balto Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gard. Timonium, Md.		
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home		25a. DATE REC'D. BY REGISTRAR MAY 5 - 1987		25b. REGISTRAR'S SIGNATURE John Anderson-Randall		
3000 E. Baltimore St.; Balto., Md. 21224						

BP _____

1-27-54
JAN 27 1954
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: Mr. J. Edgar Hoover
FROM: Mr. W. A. Rorer
SUBJECT: [illegible]
RE: [illegible]

[Faint, mostly illegible text block containing several paragraphs of correspondence.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 13574

1. DECEASED NAME (TYPE OR PRINT) HELEN P HAMILTON			20. DATE OF DEATH MONTH DAY YEAR May 11 19 87		2b. HOUR 6:26 A.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 2, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE HERMAN WATSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES BYED PRUNTY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 295-16-5487		17. INFORMANT ADDRESS FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmias DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA hemiplegia - Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic infarction - progressive APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 23 April 19 87 to 10 May 19 87 , that (I) (we) last saw the deceased alive on 10 May 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J.W. Reed M.D.				DEGREE MD.		22c. DATE SIGNED 5/11/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. REED M.D.				22e. ADDRESS 611 S. CHAS. ST. BALTO MD. 21230		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-14-1987		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Maryland
24. FUNERAL DIRECTOR NAME EVANS CHARLES OF MEMORIES ROAD		ADDRESS 8800 HARFORD		25a. DATE REC'D. BY REGISTRAR MAY 20 1987		25b. REGISTRAR'S SIGNATURE John F. ...

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1. DECEASED NAME (TYPE OR PRINT)		Henry J. Hammel		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE OF DEATH		2d. DATE OF DEATH		2e. DATE OF DEATH		2f. DATE OF DEATH	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 28, 1932		6. AGE (IN YEARS) 54		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		8. DATE PRONOUNCED DEAD 5 12 19 87		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. CITIZEN OF WHAT COUNTRY? USA		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		15. KIND OF BUSINESS OR INDUSTRY Plastics		16. CITY OR TOWN OF DEATH Baltimore		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)	
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		19. STATE Baltimore		20. CITY OR TOWN Phoenix		21. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. STREET ADDRESS 2906 Paper Mill Road 21131		23. FATHER'S NAME Henry J. Hammel		24. MOTHER'S MAIDEN NAME Marie Ann Schrufer		25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
26. SOCIAL SECURITY NO. 215-30-5674		27. INFORMANT Mr. John M. Hammel		28. ADDRESS same as # 13		29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		30. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		31. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arterioslerotic cardiovascular disease		32. DATE OF OPERATION 19a.		33. CONDITION FOR WHICH OPERATION WAS PERFORMED? 19b.	
34. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21a.		36. TIME OF INJURY 21b. HOUR 2:58 P.M. 5 12 19 87		37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in auto/fixed object impact		38. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		39. LOCATION 21f. STREET Jarrettsville Pike		40. CITY OR TOWN Pikenr. Blenheim Rd		41. COUNTY Balto,	
42. STATE MD.		43. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		44. TITLE (SPECIFY) M.D. Assistant		45. MEDICAL EXAMINER DATE 5/13/87		46. EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		47. ADDRESS 111 Penn St.		48. BALTIMORE CITY OR COUNTY OF DEATH Balto.MD.		49. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
50. DATE 5/18/87		51. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		52. LOCATION 53. CITY OR TOWN Baltimore		54. COUNTY Maryland		55. STATE Maryland		56. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. 1050 York Road		57. DATE REC'D. BY REGISTRAR MAY 15 1987		58. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 12, TO OBTAIN PAGES 4, 5, AND 6 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 300 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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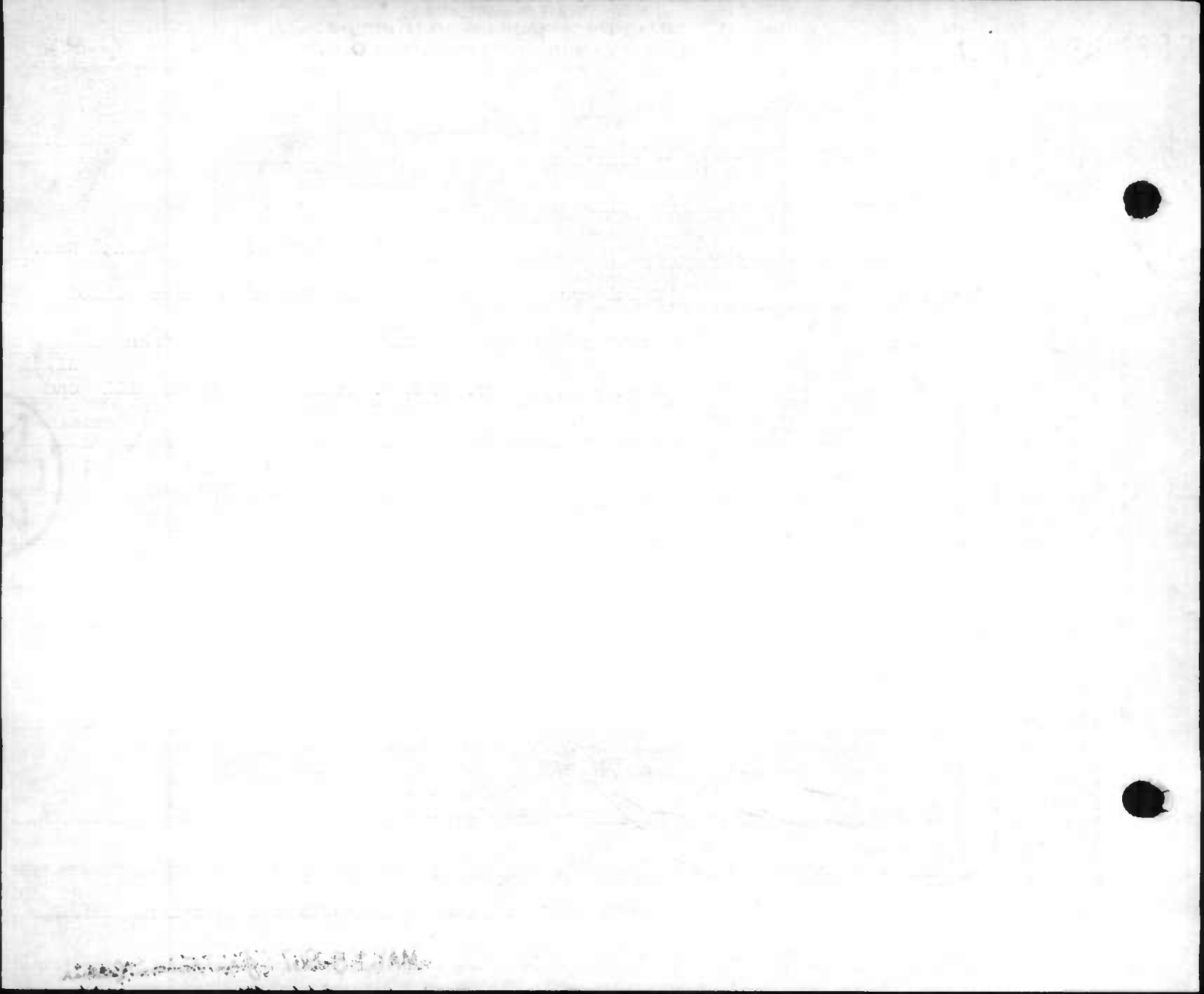
053607 MAY 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 3 5 7 6																																																											
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																					
FIRST MIDDLE LAST										MONTH DAY YEAR										M																																																																					
Marie Ann Hammel										5 12 19 87																																																																															
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										2d. HOUR																			
Female										White										Sept 27, 1909										77 YRS.																																								5 12 19 87										3:22 PM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										MD																																							
Maryland										USA										WIDOWED										DIVORCED										Baltimore City																																																	
11. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
Baltimore										University Hospital (STU)										Clerical										Social Sec.																																																											
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																	
Maryland																				Baltimore										YES										NO										4338 Parkside Drive 21206																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS										21131																													
John										Schroefer										Mary										Unknown										No										214-30-4599										Mr. John M. Hammel										2906 Paper Mill Road																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
7										8/51										IMMEDIATE CAUSE (a) Multiple injuries																																																																					
																				DUE TO, OR AS A CONSEQUENCE OF																																																																					
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										Arteriosclerotic cardiovascular disease																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES										NO																																																	
21a. EXTERNAL CAUSE WAS UNDERLYING										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																					
CONTRIBUTING										2:58 PM 5 12 19 87										Passenger in auto/fixed object impact																																																																					
21d. INJURY OCCURRED WHILE										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION										CITY OR TOWN										COUNTY										STATE																																							
AT WORK										road										Jarrettsville Pike nr. Blenheim Rd, Balto Co, MD.																																																																					
22a. I certify that I took charge of the remains described above, held on										Autopsy										Inspection										Inquiry										and in my opinion																																																	
death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED										5/13/87																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										111 Penn St.										Balto. MD.																																																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										CITY OR TOWN										COUNTY										STATE																													
Burial										5/18/87										Most Holy Redeemer										Baltimore										Maryland																																																	
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Ruck Towson Funeral Home, Inc. 1050 York Road																				MAY 15 1987										Julia Anderson-Randall																																																											

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen V. Hancock				2a. DATE OF DEATH MONTH DAY YEAR 5/17/87				2b. HOUR 9:05 pm	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5/24/13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6706 Brighton Avenue 21215	
14. FATHER'S NAME FIRST MIDDLE LAST David Myers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie P. Reedy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-07-6873		17. INFORMANT ADDRESS Mr. Wilbur N. Hancock Baltimore Maryland 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/29/87 - 5/17/87									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/29 , 19 87 , to 5/17 , 19 87 , that (I) (we) last saw the deceased alive on 5/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. George				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sue E. George MD				22e. ADDRESS 900 S. Caton Ave. Balto. Md. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/87		23c. NAME OF CEMETERY OR CREMATORY David Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown Maryland 21133				25a. DATE REC'D. BY REGISTRAR MAY 19 1987 25b. REGISTRAR'S SIGNATURE Richard R. Riddick					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and addresses of the members of the committee. The names are written in a cursive hand, and the addresses are given in a more formal, printed style. The list is organized in a table-like format with columns for names and addresses.

2. The second part of the document is a list of names and addresses of the members of the committee. The names are written in a cursive hand, and the addresses are given in a more formal, printed style. The list is organized in a table-like format with columns for names and addresses.

3. The third part of the document is a list of names and addresses of the members of the committee. The names are written in a cursive hand, and the addresses are given in a more formal, printed style. The list is organized in a table-like format with columns for names and addresses.

4. The fourth part of the document is a list of names and addresses of the members of the committee. The names are written in a cursive hand, and the addresses are given in a more formal, printed style. The list is organized in a table-like format with columns for names and addresses.

5. The fifth part of the document is a list of names and addresses of the members of the committee. The names are written in a cursive hand, and the addresses are given in a more formal, printed style. The list is organized in a table-like format with columns for names and addresses.

053977 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 7 8

REG. NO.

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST MARGARET W. HAND			2a. DATE OF DEATH MONTH DAY YEAR 5/17/87		2b. HOUR 8:16 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 29 11		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Work		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Cleveland Harrison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Swann		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217030082	
17. INFORMANT Randallstown		ADDRESS MD Apt 207		Mrs. Edith Kalter 3801 Schnaper Dr.		21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma of Breast						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 14 19 87 to May 17 19 87 , that (I) (we) lost saw the deceased alive on May 17 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jorge J. Acevedo		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge J. Acevedo		22e. ADDRESS 3001 S. Hanover St. Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-21-87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel MD	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc ADDRESS 8728 Liberty Rd. Randallstown, MD 21133				25a. DATE REC'D. BY REGISTRAR MAY 19 1987		25b. REGISTRAR'S SIGNATURE Lina Rodon-Rodriguez	

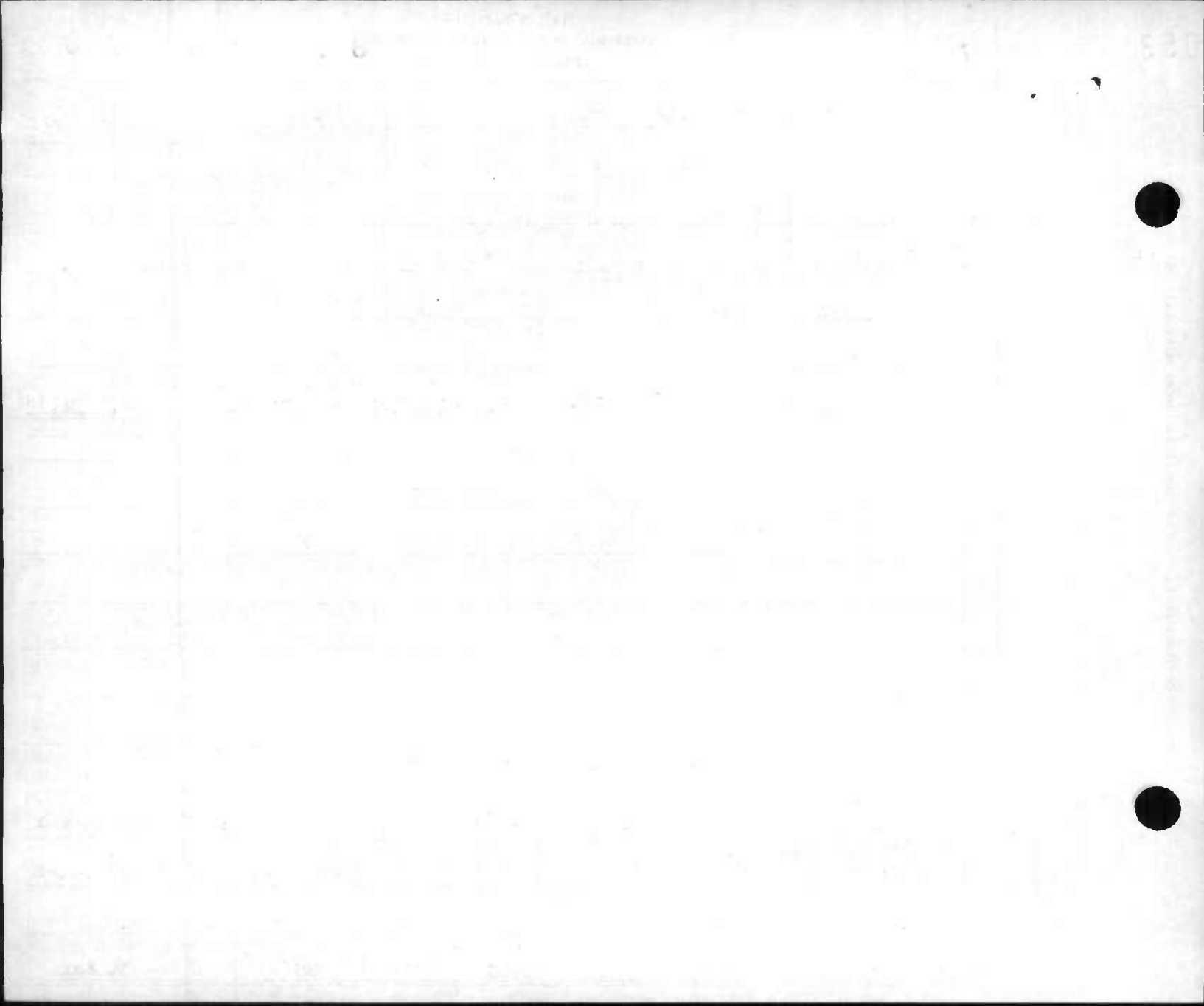
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

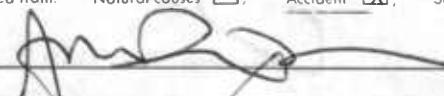
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



054376 MAY 25 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13579 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Trammel Handley										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 19 1987		2b. HOUR M 6:03 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 12 1905		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 82 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
11. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. STATE Maryland				13b. COUNTY Garrett		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 152, Oakland, Md. 21550 17074 Big Falls Rd., 21111			
14. FATHER'S NAME FIRST MIDDLE LAST John P. Trammel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emmie Brownlee				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 090 092-12-4543	
17. INFORMANT ADDRESS Hugh D. Handley, Jr., 17074 Big Falls Rd., 21111				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 PM 5 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of auto in auto/auto collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE York & McCormick Roads, Cockeysville, Balto., MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 5-20-87					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/23/87		23c. NAME OF CEMETERY OR CREMATORY Garrett Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland		25a. DATE REC'D. BY REGISTRAR MAY 21 1987			
24. FUNERAL DIRECTOR NAME Martin D. Lawson				25b. REGISTRAR'S SIGNATURE Martin D. Lawson									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 13580	
1. FOR STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Erma I. Haney					2a. DATE OF DEATH MONTH DAY YEAR 5 3 87					2b. HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 7 16		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 72 HRS. HOURS MIN. 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Anne Arundel Pasadena		13b CITY OR TOWN Pasadena		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Pasadena, Md. 318 A Bar Harbor Rd. #21122					
14 FATHER'S NAME FIRST MIDDLE LAST Clinton O. DeHof					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie F. Barth						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b SOCIAL SECURITY NO. 215-03-3328		17. INFORMANT ADDRESS 318 A Bar Harbor Rd. - Pasadena, Md. #21122				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 911 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Aspiration while eating APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr 2hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Left hemiparesis, Total Blindness.											
19a. DATE OF OPERATION July 8, 1986				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Total Blindness				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19		21f LOCATION STREET CITY OR TOWN COUNTY STATE 11329 Rolling Rd. Balt. Md. 21222					
22a I certify that (I) (this hospital) attended the deceased from July 8, 1986 to May 3, 1987 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on April 3, 1987 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b SIGNATURE W. Nelson McKay MD								DEGREE MD		22c. DATE SIGNED 5/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W. Nelson McKay MD								22e ADDRESS 11329 Rolling Rd. Balt. Md. 21222			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-7-87		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24 FUNERAL DIRECTOR G. Truman Schwab					5151 Balto. Nat'l Pike #21229		25a. DATE REC'D. BY REGISTRAR MAY 5 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

053875 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13581					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADDIE HANKIN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 10 1987		7b. HOUR M 7:10A			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3/1/1910		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 77		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 10 1987		7d. HOUR M 7:10A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3819 Ferndale Avenue				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. STATE Maryland				13b. COUNTY Balto City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3819 Ferndale Avenue 21207					
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT McDonald Bagley				ADDRESS 5508 Stonington Avenue 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5/10/87			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St.				BALTO.MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY Westview Mem Park				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Baltimore Co., Md					
24. FUNERAL DIRECTOR JAMES N. KOTSIS F.H.,				ADDRESS 6411 Windsor Mill Rd.				25a. DATE REC'D BY REGISTRAR MAY 18 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove outside covers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 8 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna T. Harcarik			2a. DATE OF DEATH MONTH DAY YEAR 5/4/87			2b. HOUR 7:35 AM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1/15/91		6. AGE (IN YEARS LAST BIRTHDAY) 96		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.			13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4302 Sheldon Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Tesack					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Sorma					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-22-7959		17. INFORMANT ADDRESS Anges Koerner (dtr) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Circulatory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recurrent Urinary Tract Infections; Organic Brain Syndrome									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours days years	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/30/82 to 5/4/87 , that (I) (we) last saw the deceased alive on 4/14/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Albert B Bradley					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Bradley, MD					22e. ADDRESS 4900 Belair Road, Balto., Md. 21213					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/7/87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213					25a. DATE REC'D. BY REGISTRAR 8 1987		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 1-JACOB ² (JACK) HANOVER		2a. DATE OF DEATH MONTH DAY YEAR 05 24 87		2b. HOUR 10 ²⁵ AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 07 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.
7a. BIRTHPLACE (COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AGENT	12b. KIND OF BUSINESS OR INDUSTRY LIFE INSURANCE
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HASKIN HANOVER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-16-6009A	17. INFORMANT ADDRESS CLARA HANOVER 6310 GREENSPRING AVE. APT. 101 (21209)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic squamous cell carcinoma of unknown primary. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/27/87, to 5/24/87, that (I) (we) lost saw the deceased alive on 5/27/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE R. Keren M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RON KEREN		22e. ADDRESS SINAI HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/27/87	23c. NAME OF CEMETERY OR BURIAL LOCATION BETH ISRAEL CEM. BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BRUS INC. 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. DATE REC'D. BY REGISTRAR MAY 28 1987		
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendley		

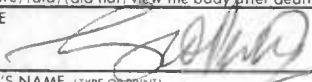

BP

53458 MAY 14 1987

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 8 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRA JAMES HARCUM			2a. DATE OF DEATH MONTH DAY YEAR 05 07 87		2b. HOUR 2⁰⁵ PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 20 99		
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 00 00		8. IF UNDER 74 HRS HOURS MIN. 00 00		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LONGSHOREMAN		
12b. KIND OF BUSINESS OR INDUSTRY SHIPPING		13a. STATE MARYLAND		13b. COUNTY BALTIMORE		
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BALTIMORE, 3924 NORFOLK AVE. MD, 21216		
14. FATHER'S NAME FIRST MIDDLE LAST DAVID HARCUM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA AUGUSTUS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.		
16b. SOCIAL SECURITY NO. 216-10-6308		17. INFORMANT MRS. LOIS CLARK		17. ADDRESS BALTIMORE, MARYLAND 3924 NORFOLK AVE. 21216		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC HEART DISEASE						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. ANAEMIA, CEREbro-VASCULAR DISEASE, HAEMATURIA						
19a. DATE OF OPERATION 5-4-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLADDER STONES		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE -		22a. I certify that (I) (this hospital) attended the deceased from 4-26-1987 to 5-7-1987 , that (I) (we) last saw the deceased alive on 5-7-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE  DEGREE MD		
22c. DATE SIGNED 5-7-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHIR D. PATEL		22e. ADDRESS LIBERTY MEDICAL CENTRE BALTIMORE MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/11/1987		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		24. FUNERAL HOME NAME ADDRESS NUMBER 4 SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216		25a. DATE REC'D. BY REGISTRAR MAY 13 1987		
25b. REGISTRAR'S SIGNATURE 						

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

THURSDAY JUL 11 1958

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 8 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charlotte LOUISE HARDY			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1987		2b. HOUR 8:30AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-28-1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bar Mngt.	12b. KIND OF BUSINESS OR INDUSTRY Owner
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS AND CODE 1209 W. Bayside St. 21230
14. FATHER'S NAME FIRST MIDDLE LAST Edward Inez Young		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verna May Turner		16. ADDRESS 1209 W. Bayside St. 21230	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-14-4669		17. INFORMANT Julia Gordon-Randall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Urosepsis, Stage III glioma with secondary metastasis. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 5, 1987, to May 8, 1987, that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on May 8, 1987, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) not view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Marilyn Perry,		22c. ADDRESS c/o Maryland General Hospital		22d. DATE SIGNED 8 MAY 87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-12-1987	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	23e. DATE REC'D. BY REGISTRAR MAY 14 1987
24. FUNERAL DIRECTOR John J. Cronan & Son, Inc.		24b. ADDRESS 401 Thelma St.		24c. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

THE ATTORNEY

053828

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ERVING	MIDDLE D	LAST HARDY	2a. DATE OF DEATH MONTH DAY YEAR MAY 13, 1987		2b. HOUR 12:54 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 17 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 407 S. Harrison Street 21601		14. FATHER'S NAME FIRST MIDDLE LAST Robert Thomas Hardy, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Milligan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Juanita C. Hardy P O Box 1149 Easton MD 21601				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Exercise Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery / Portal HTN</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 hr</u> <u>4 hr</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Probable Alcoholic Cirrhosis</u>								
19a. DATE OF OPERATION 5/13/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abd. Aortic Aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Broadway (S.H.H.) Balt. MD 21215</u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>87</u> , to <u>5/13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mad Long</u>				22e. ADDRESS <u>511st - Broadway, Balt., MD 21215</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED AS NON-MED- DR. ZANE PER MR. GREY

5/13/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Page 4 should be retained by the funeral director. Page 5 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified.

BP

85352

7-10-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. If the deceased was a resident of Baltimore, page 1 and 2 should be filed with the Health and Mental Hygiene Department, 201 W. Preston St., Baltimore, Maryland 21201. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

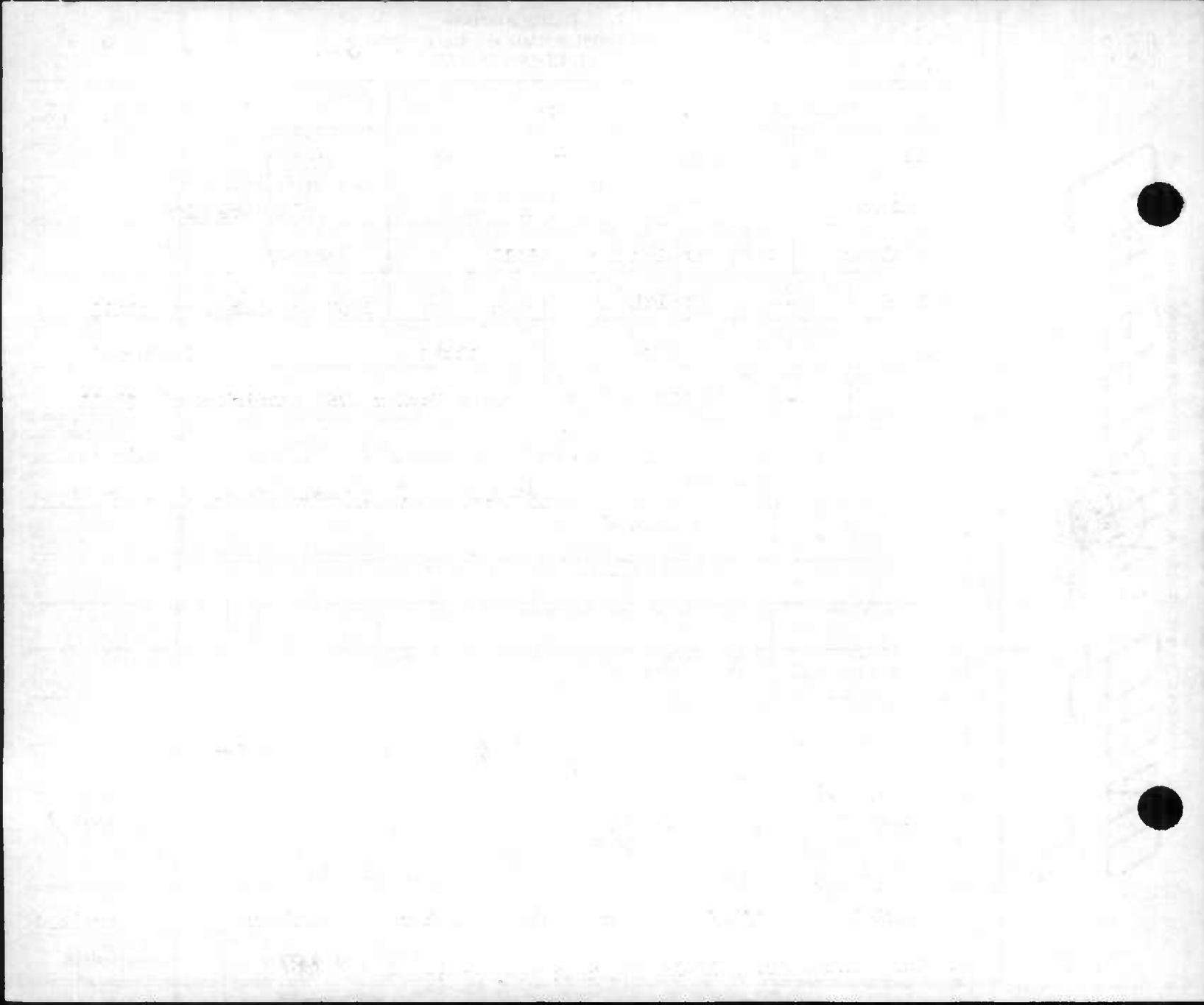
10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13587

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence A. Hare		2a. DATE OF DEATH MONTH DAY YEAR 05 12 87		2b. HOUR 6:15 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 06 1898	
6. AGE (IN YEARS LAST BIRTHDAY) 97 89 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3757 Keswick Road 21211		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3757 Keswick Road 21211			
14. FATHER'S NAME FIRST MIDDLE LAST Amos Hare		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Lavena Taylor 3757 Keswick Road 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Schlemmer throat cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Years.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>87</u> , to <u>5/12</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Em. Dugan</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/14/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Em. DUGAN</u>		22e. ADDRESS <u>500 W. University Pkwy Baltimore, MD 21210</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.		ADDRESS 3615-19 Chestnut Ave.		25a. DATE REC'D. BY REGISTRAR MAY 14 1987	
		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

BP



056308 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

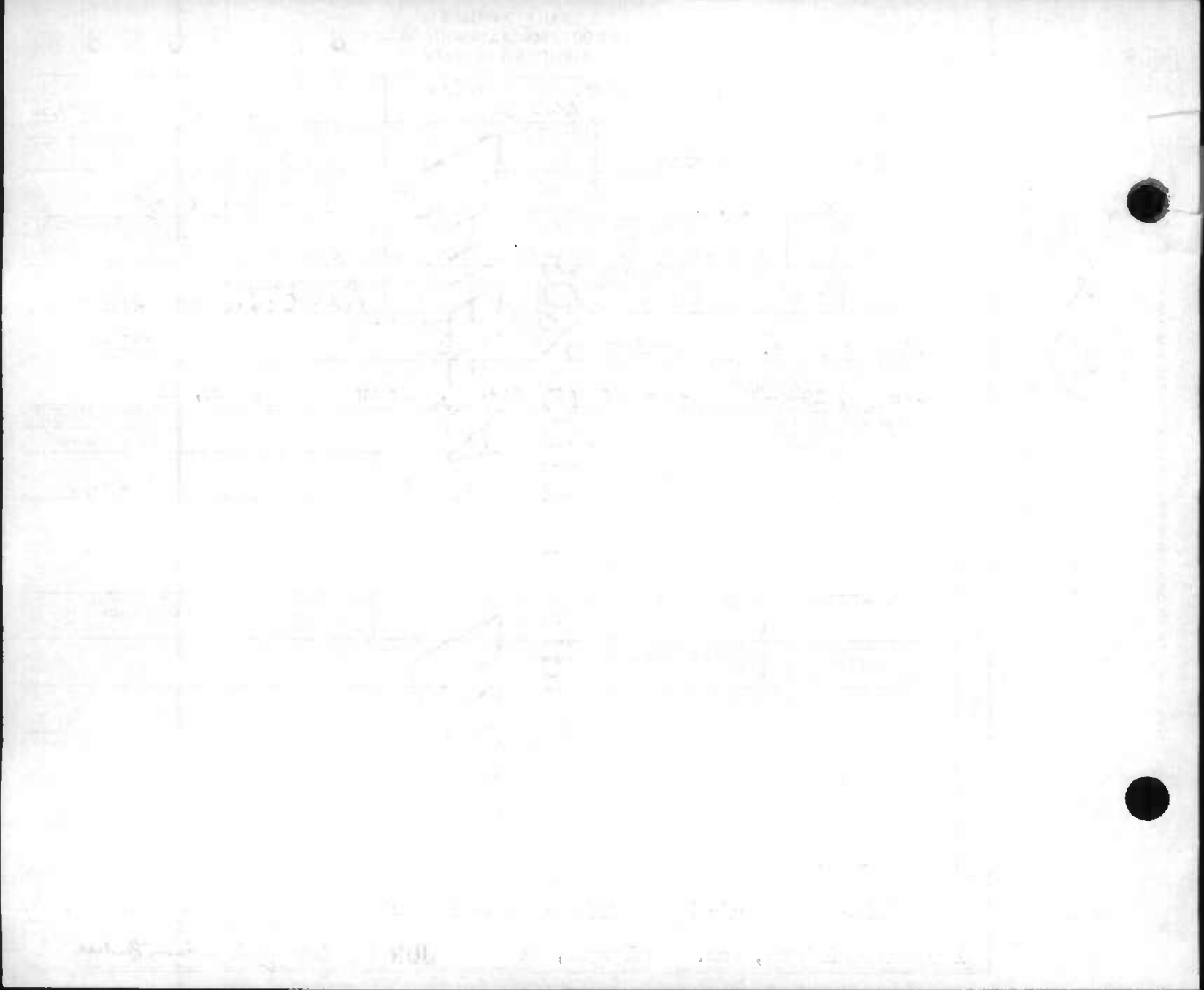
8 7

1 3 5 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Reginald Stuart Harlow			2a. DATE OF DEATH MONTH DAY YEAR 5 31 87		2b. HOUR 1249 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 25 27		6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY H. A.	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Harlow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Kilby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-47 224 320545		17. INFORMANT ADDRESS Edith K. Harlow Culpeper, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-31 , 19 87 , to 5-31 , 19 87 , that (I) (we) last saw the deceased alive on 5-31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Rosenbloom				22c. DATE SIGNED 5-31-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark K. Rosenbloom, MD				22e. ADDRESS 3001 S. Hanover Dr., Baltimore, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-5-87		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memory Gardens	
24. FUNERAL DIRECTOR NAME Clore Funeral Home, Inc.		ADDRESS Culpeper, VA		25a. DATE REC'D. BY REGISTRAR JUN 10 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13589

1- FOR
STATE
REGISTRAR

11. DECEASED NAME
(TYPE OR PRINT)

Beatrice

Harris

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 5-31 1987 2b. HOUR M

3. SEX F

4. RACE B

5. DATE OF BIRTH MONTH DAY YEAR 12 22 1970

6. AGE (IN YEARS) (LAST BIRTHDAY) 70 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD 5-31 1987 2d. HOUR M 3:04A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 221 N. Fremont Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House work 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD

13b. COUNTY

13c. CITY OR TOWN Balto

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 221 N. Fremont Ave

14. FATHER'S NAME FIRST Claude

MIDDLE LAST Martin

15. MOTHER'S MAIDEN NAME FIRST Cotty

MIDDLE LAST Stark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 241-32-8727

17. INFORMANT ADDRESS Shein Dildy 3805 Fernhill Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Neurosyphilis (by history)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margaret A. Korell

TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 5-31-87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 6-6-87

23c. NAME OF CEMETERY OR CREMATORY MT Auburn

23d. LOCATION CITY OR TOWN Balto.

COUNTY

STATE MD

24. FUNERAL DIRECTOR

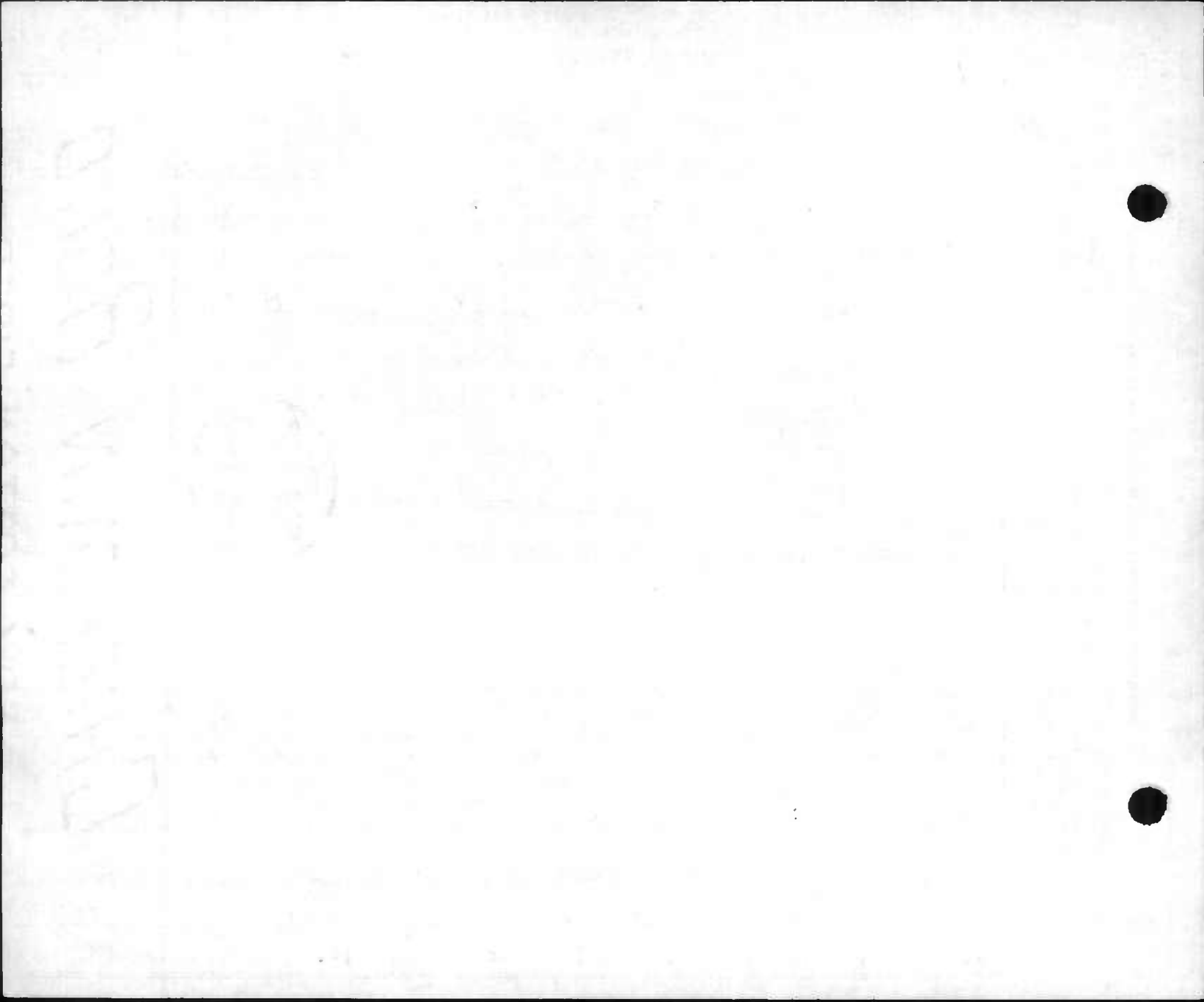
NAME Wm C. Brown

ADDRESS 1206 W. North Ave

25a. DATE REC'D. BY REGISTRAR JUN 10 1987

25b. REGISTRAR'S SIGNATURE Julia T. Brown-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETURN PAGE 4 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 9 0

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHAD WAYNE HARRIS			2a. DATE OF DEATH MONTH DAY YEAR MAY 7, 1987		2b. HOUR 5:55P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN 14, 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 3 23	IF UNDER 1 YEAR IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST DAVID L. HARRIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DEBBIE I. LOHRMANN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS DAVID L. HARRIS (FATHER) SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LEFT VENTRICULAR FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>SIF REPAIR TETRALOGY OF FALLOT</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION 5-7-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TETRALOGY OF FALLOT		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>87</u> , to <u>5-7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5-7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>SHUMWAY</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHUMWAY		22e. ADDRESS 618 BLALOCK BLDG JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 11, 1987		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MD.					
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME, GLEN BURNIE, MD. 21061		25a. DATE REC'D. BY REGISTRAR MAY 12 1987			
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

9 2333

214 ROAD TOWN OF BOSTON
1000 WATERMAN STREET
CARDINAL ARREST

42-14

2-2-67 10:00 AM in the city

Shawmut
214 Road

2-2-67
CIT. OF BOSTON
214 ROAD TOWN OF BOSTON

054662 MAY 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13591

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
DOROTHY Mae HARRIS						DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>			5-22-87 ¹⁹		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
female	black	6 13 1941	45 YRS.			5-22-87 ¹⁹			3:20a		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md			U S A						Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			4500 blk. Pall Mall Road			Housewife					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
James			Louise			No			216-42-4345		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Roy W. Harris, Sr			PART I DEATH WAS CAUSED BY:								
			IMMEDIATE CAUSE (a) Shotgun wound of chest and arm								
			DUE TO, OR AS A CONSEQUENCE OF								
			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			? P.M. 5-22-87			subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
			on the street			4700 blk. Pall Mall Rd Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from											
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
			Deputy chief			5-22-87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Ann M. Dixon, M.D.			111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			5/27/87			Druid Ridge Cemetery			Balto Co Md		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H West 4300 Wabash Avenue			MAY 27 1987								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 13592
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie Harris		2a. DATE OF DEATH MONTH DAY YEAR May 22 1987		2b. HOUR 10⁰⁰ P M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 4 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREENWOOD S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At home		13a. STREET ADDRESS / ZIP CODE 3425 Normount Ave	
13a. STATE MD		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wm Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amann		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 213-03-9152		17. INFORMANT Belton J. Lee		ADDRESS 535 Wilkerson Pkwy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Gangrene, foot					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 6 days 5 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCVD w/ cardiac arrhythmias, decubitus ulcers, dementia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from March 24, 1987 to May 22, 1987 , that (I) (we) last saw the deceased alive on May 22, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. DATE SIGNED 5/22/87	
22c. SIGNATURE David A. Jung		22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung		22e. ADDRESS Liberty Medical Center	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/25/87		23c. NAME OF CEMETERY OR CREMATORY Arboretum Mem. Pk	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD 21227		24. FUNERAL DIRECTOR NAME Marshall P. Hayes		25a. DATE REC'D. BY REGISTRAR MAY 27 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. ADDRESS 638 N. Calver		25d. DATE REC'D. BY REGISTRAR MAY 27 1987	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 3 5 9 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: Milton MIDDLE: H LAST: Harton JR			2a. DATE OF DEATH MONTH: 5 DAY: 5 YEAR: 87		2b. HOUR 5 P M		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH: 6 DAY: 21 YEAR: 20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Joseph Richey Hospice House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3160 WILKINS AVE, 21223		14. FATHER'S NAME FIRST: UNKNOWN MIDDLE: LAST: HARTON		15. MOTHER'S MAIDEN NAME FIRST: ELIZABETH MIDDLE: LAST: UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES 1937-39	
16b. SOCIAL SECURITY NO. 244-26-5346		17. INFORMANT CONCETTA HARTON		17. ADDRESS 3160 WILKINS AVE.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SMALL CA. OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) TOBACCO ABUSE DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 4, 1986 to MAY 5, 1987, and that (I) (we) last saw the deceased alive on above, (I) (we) did not view the body after death.							
22a. SIGNATURE Diana H. Corbett		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/6/87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA H. CORBETT		22d. ADDRESS 900 CATON AVE. BALT. MD 21209					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-6-87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM A		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME EDWARD J. WEBER		ADDRESS 5311 EDMONDSON AVE		25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

053 178 MAY 11 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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Office in
St. Louis
Mo.
268-0000
J. G. Smith

055175 JUN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13594

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUDWIN LEROY HARVEY			2a. DATE OF DEATH MONTH DAY YEAR 05- 27 87		2b. HOUR 1016 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 16 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control		12b. KIND OF BUSINESS OR INDUSTRY Locke Insul.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Balto. City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Harvey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Caskey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Alice June Harvey, same as 13		
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electromechanical dissection DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 5/26 , 19 87 , to 5/27 , 19 87 , that (1) (we) lost saw the deceased alive on 5/27/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stephen Plant		DEGREE PLANTH001		22c. DATE SIGNED 5/27/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PLANTH001		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 May 87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A., MD		24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD 21061		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		
25b. REGISTRAR'S SIGNATURE Julia Swinson-Rudace						

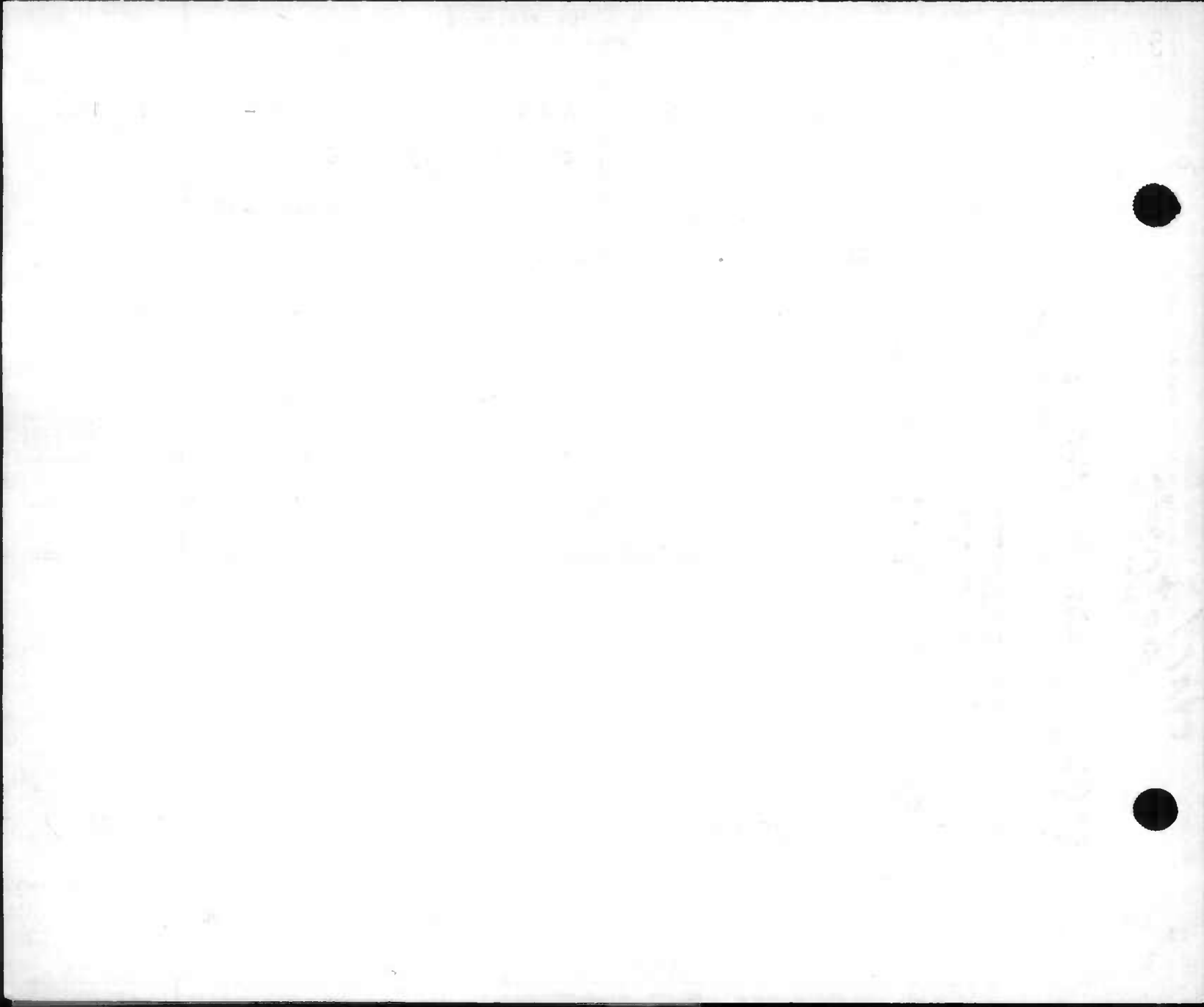
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified of once.

BP



052995 MAY 11

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 ! 3595

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edgar H. Harvey, Jr.			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1987			2b. HOUR 12:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar H. Harvey, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Lord			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Thomas Harvey 1439 Via Sevilla		91750	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>possible sepsis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>87</u> , to <u>5/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B. Fleming</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/3/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. Fleming</u>				22e. ADDRESS <u>Francis Scott Key Med Ctr</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-9-87		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk				25a. DATE REC'D. BY REGISTRAR MAY 8 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rudick</u>	
7922 Wise Ave. Dundalk, MD 21222							

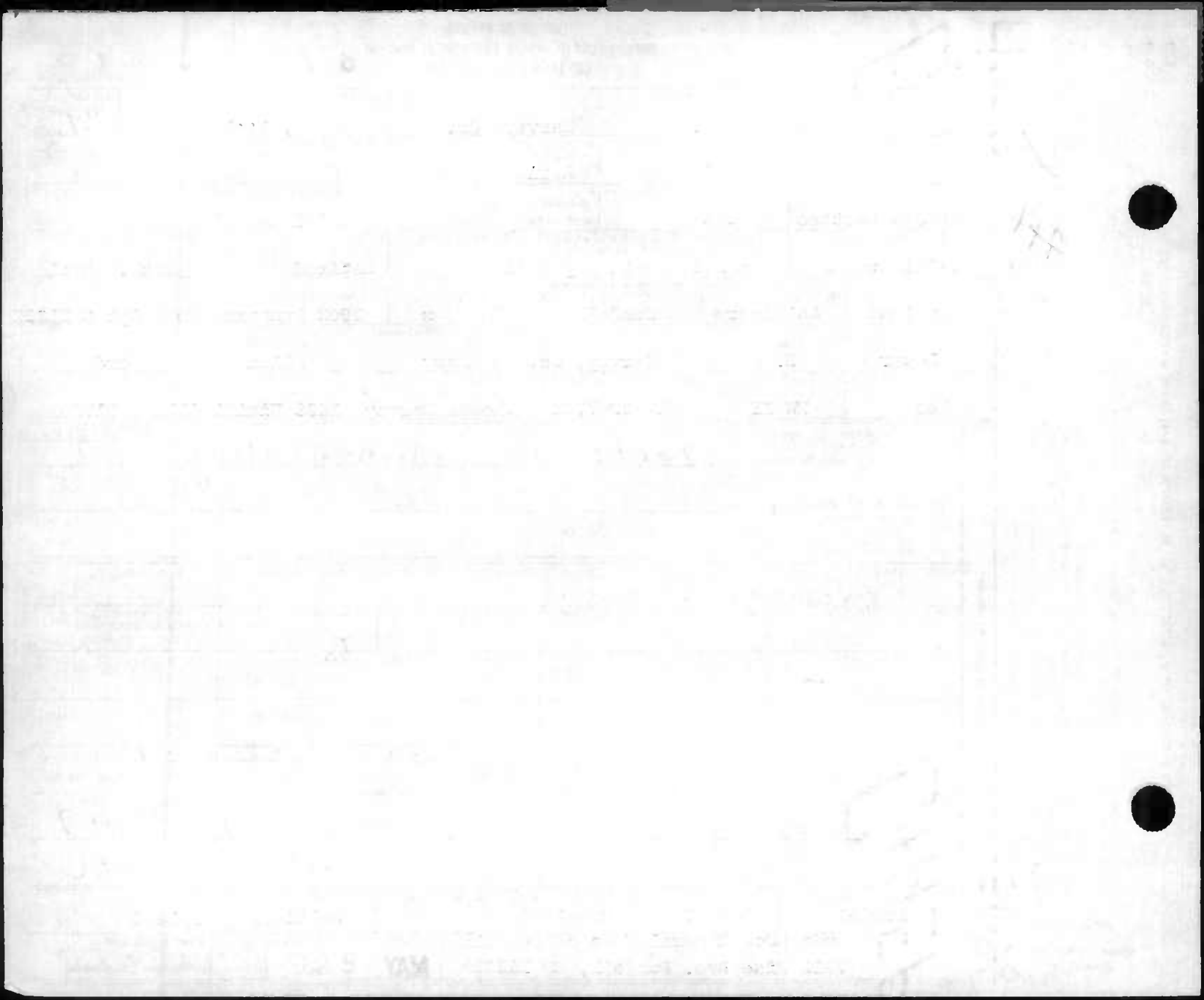
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.



053248

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 3 5 9 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret Harvin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 4, 1987</i>		2b. HOUR <i>9:14P</i> M		
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4/1/27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Mose Riley</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Daisy Riley</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Sammie Harvin 326 N. Schroeber St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute hemorrhagic erosive gastritis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Micronodular cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aspiration pneumonia</i> PART II. OTHER NON-FATAL DISEASES OR CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART I: <i>d. Hypertensive heart disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>April 27</i> , 19 <i>87</i> , to <i>May May 4</i> , 19 <i>87</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>May 4</i> , 19 <i>87</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <i>(not)</i> view the body after death.							
22b. SIGNATURE <i>James E Kelly DO</i>				DEGREE <i>DO</i>		22c. DATE SIGNED <i>5/5/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James E. Kelly, D.O.</i>				22e. ADDRESS <i>c/o Maryland General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/9/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus, B.C. MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Charles A. Rice FSPA 1300 Eutaw Pl,</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 11 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

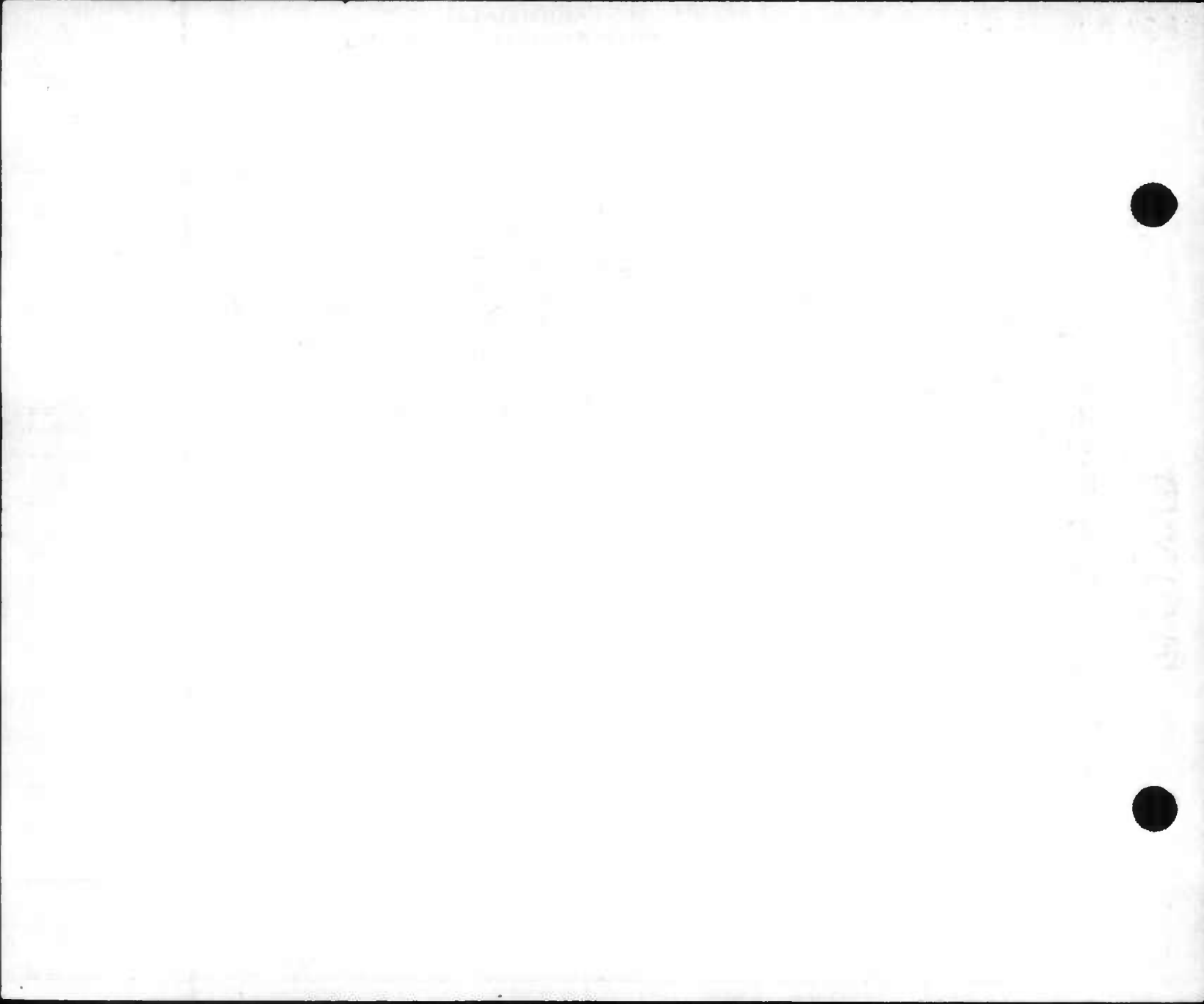
1.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE R. HASSELL			7a. DATE OF DEATH MONTH DAY YEAR 5/19/87		7b. HOUR 8:50 AM					
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 13 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty MED CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY -				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BAIT.		13c. CITY OR TOWN BAIT.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 854 Whitmore Ave 21216	
14. FATHER'S NAME FIRST MIDDLE LAST UNKN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-6989		17. INFORMANT Jane Hassell		ADDRESS 854 Whitmore Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Linda S. Ellis		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD C. CULLEN		22e. ADDRESS LIBERTY MEDICAL CENTER								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/23/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H West 4300 Wabash Ave.				25a. DATE REC'D. BY REGISTRAR MAY 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP _____



052723

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 7 1 3 5 9 8
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST EDGAR AUGUSTA HATFIELD		MONTH DAY YEAR 5 5 87	
3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR 8 14 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY M.T.A.	
13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1031 S. Beechfield Ave. 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hatfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Conway	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-10-0043	
17. INFORMANT ADDRESS Joseph F. Yates 426 Shadynook Ave. 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL LOWER LOBE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ASTHMATIC BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Michael E. Pelczar MD		22c. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR MD		22e. ADDRESS St. Agnes Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/87	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25. REGISTRAR'S SIGNATURE DATE RECEIVED MAY 6 1987 REGISTRAR'S SIGNATURE John Dendron-Randall	

BP

DHMH - 16 60M 7/B4

(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

055219 JUN 1

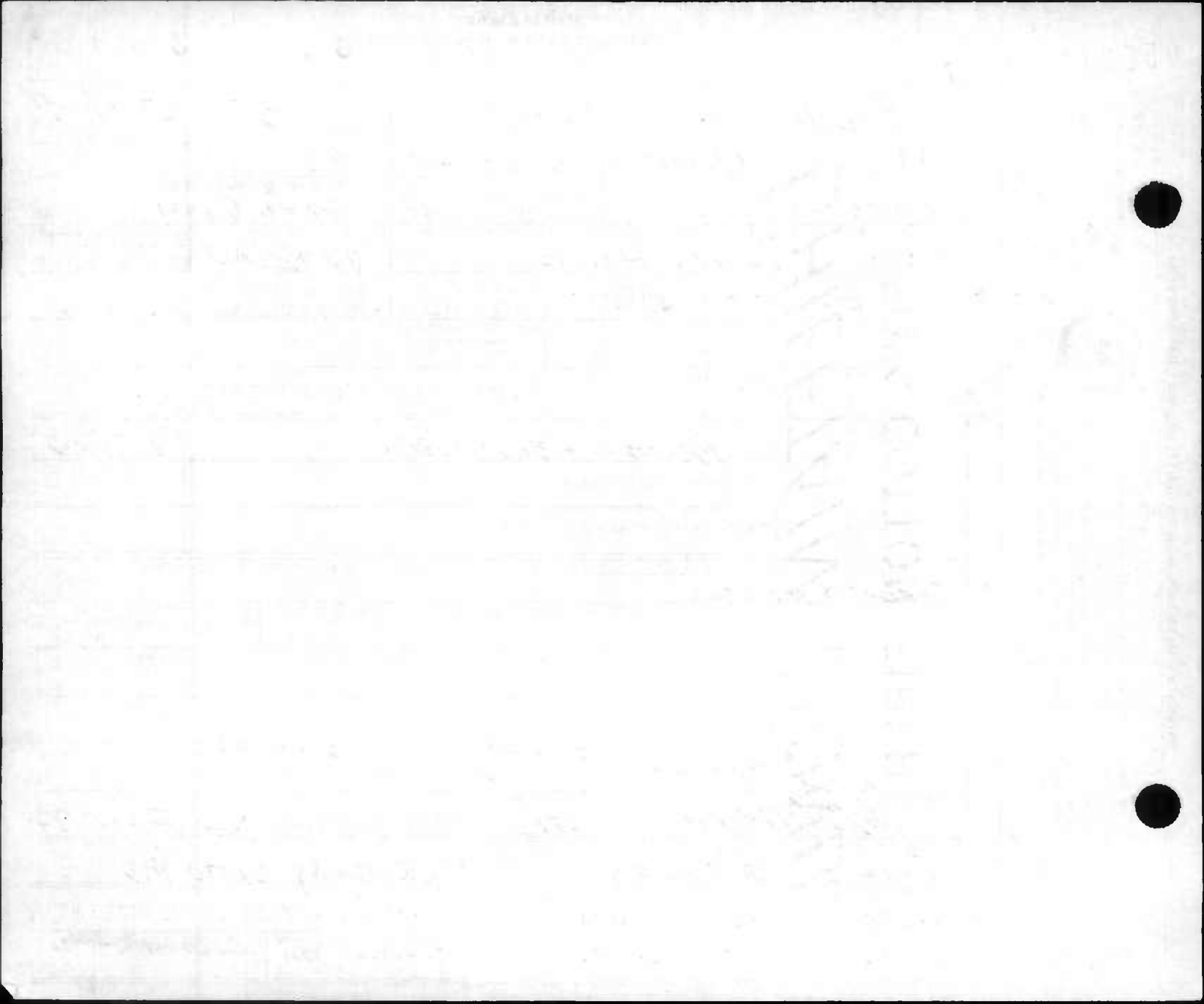
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13599

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELMA H. HAUX			2a. DATE OF DEATH MONTH DAY YEAR 5 24 87		2b. HOUR 4:45 PM
3. SEX M ALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 2 25 1915		6. AGE (IN YEARS (LAST BIRTHDAY)) 72	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN		12b. KIND OF BUSINESS OR INDUSTRY PLATE GLASS
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HANS HAUX		15. MOTHER'S MAIDEN NAME MIDDLE LAST LOUTSE HILL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) WWII		16b. SOCIAL SECURITY NO.		17. INFORMANT ROBERT HAUX ADDRESS 660 AMERICANA DR. 21403 ANNAPOLIS MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER HEAD & NECK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-18-87 , 19____, to 5-24-87 , 19____, that (I) (we) last saw the deceased alive on 5-24-87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul E. Gormanley		DEGREE MD		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. GORMANLEY		22e. ADDRESS 100 N BROADWAY CATO MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 5-25-87	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN ALEXANDRIA FAIRFAX VIRGINIA		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR ROBERT E. EVANS		1212 WEST ST. ANNAPOLIS, MD		25a. DATE REC'D. BY REGISTRAR JUN 1 1987	
				25b. REGISTRAR'S SIGNATURE Julia B. [Signature]	

BP _____



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DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

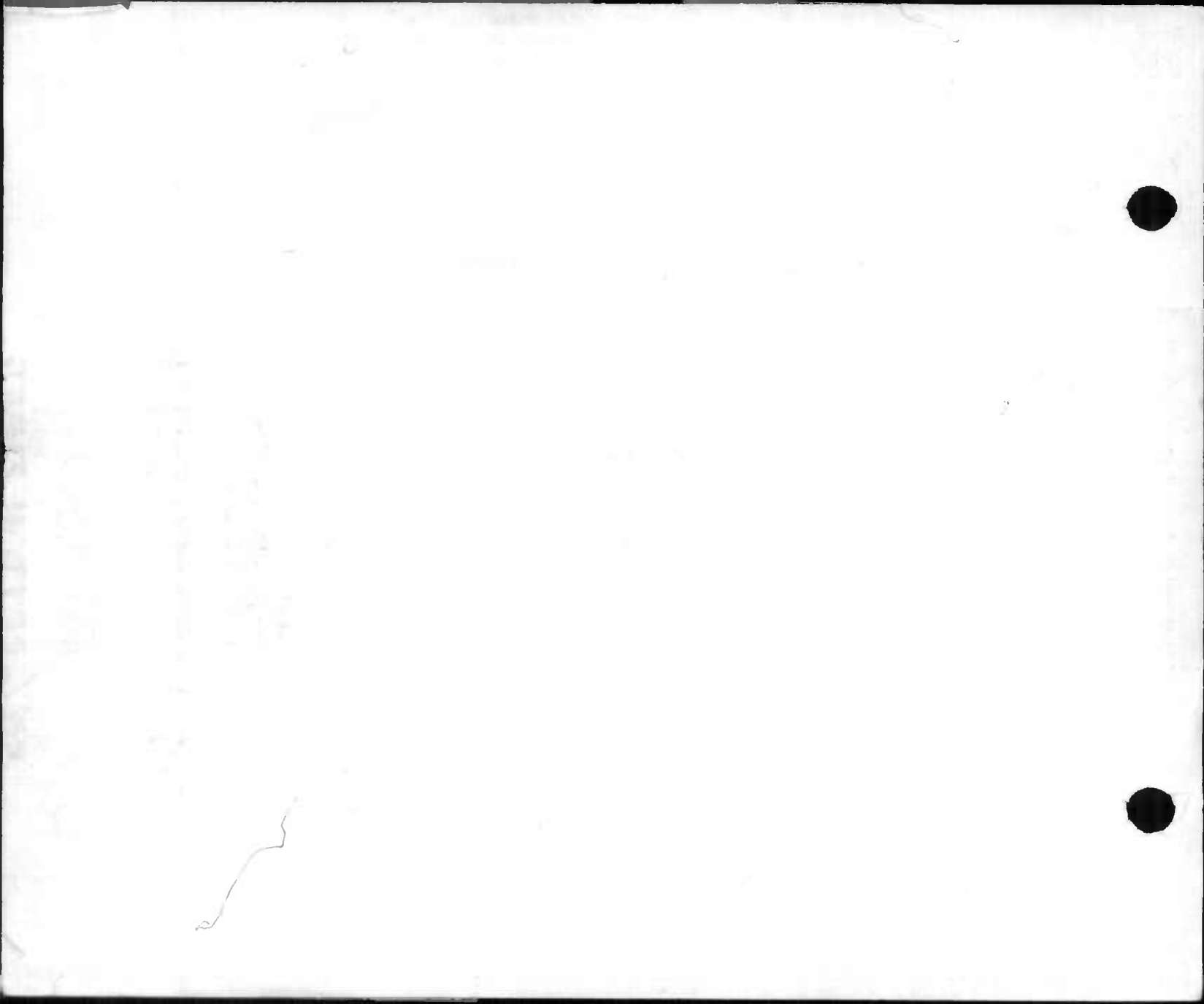
13600

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Victoria Hawkins			2a. DATE OF DEATH MONTH DAY YEAR May 22, 1987		2b. HOUR 2:40 A.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 16 07		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn.		
16b. SOCIAL SECURITY NO. 216-58-1959		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Decubitus Ulcers		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHF 2° ASCVD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 2 May , 19 87 , to 22 May , 19 87 , that (I) (we) last saw the deceased alive on 22 May , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE David Jung MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22c. DATE SIGNED 5/22/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Jung		22e. ADDRESS Liberty Medical Center		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-24-87		23c. NAME OF CEMETERY OR CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board Balto., Md.		25. DATE REC'D. BY REGISTRAR JUN 01 1987		
26. REGISTRAR'S SIGNATURE <i>Julia Tindem...</i>						

BP



054225 MAY 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13601

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marguerite L. HAYNIE			2a. DATE OF DEATH MONTH DAY YEAR 5-15-87		2b. HOUR 4:58 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-6-13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home
13a. STATE Md.		13b. COUNTY BALTO.		13c. STREET ADDRESS / ZIP CODE 206 S. WOODYEAR ST. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN / KRAUSE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary / WEBER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-18-0975		17. INFORMANT Abner L. Haynie Jr. ADDRESS 7764 Edgewood		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) severe congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Sepsis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/15 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/14 19 87 , to 5/15 19 87 , that (I) (we) last saw the deceased alive on 5/15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE CD Kearney MD		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER D. KEARNEY		22e. ADDRESS 700 WASH. BLVD BALT MD				
23a. BURIAL, CREMATION, REMOVAL (CHECK IF) Burial		23b. DATE 5-19-1987		23c. NAME OF CEMETERY OR CREMATORY Bethel Hill Con.		
23d. LOCATION CITY OR TOWN COUNTY Bethel Hill Con.		24. FUNERAL DIRECTOR NAME John J. Lawan & Son Inc.		25a. DATE REC'D. BY REGISTRAR 901 Hollins St		
25b. ADDRESS 901 Hollins St		25c. DATE REC'D. BY REGISTRAR MAY 21 1987				

MEDICAL CERTIFICATION

29

BP

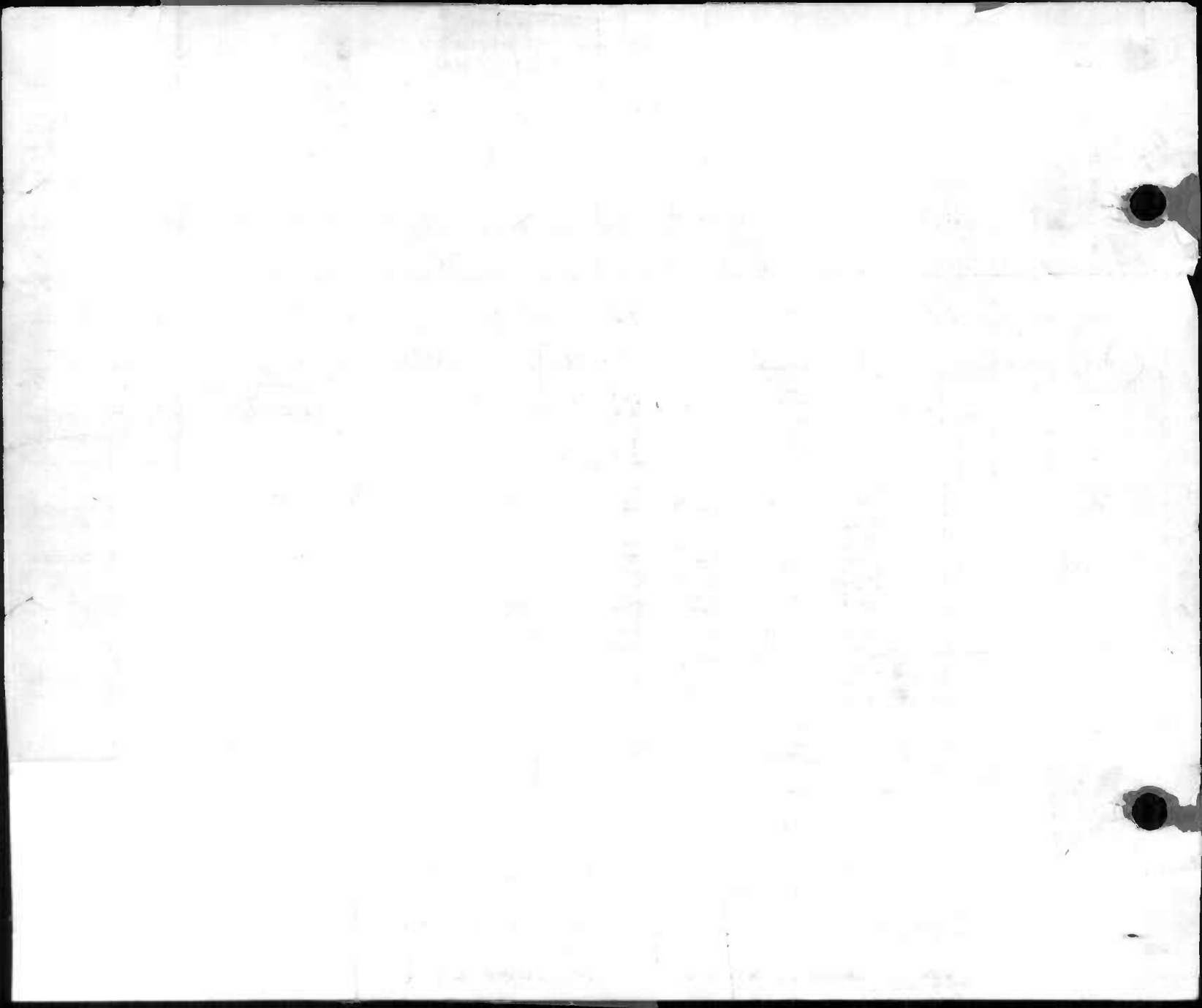
DHMH : 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



55637 JUN-5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbett permit. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 24 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

13602

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				
LOU E. HEARD					JUN 30 87			2-55A-M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
F	B.	MONTH DAY YEAR		54		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MO		USA				Baltimore City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Bon Secours		N/A				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MO				Baltimore		714 Lennox St. 21217		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		
Eugene		Josephine		NO		215-30-0067		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Toni J. Heard		PART 1. DEATH WAS CAUSED BY:				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
1712 N. Warwick Ave		IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		DUE TO, OR AS A CONSEQUENCE OF						
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
		DUE TO, OR AS A CONSEQUENCE OF						
		(c)						
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19. that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
		THOMAS S. MILLER						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
THOMAS S. MILLER, MD		Bon Secours Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		6/4/87		Arbutus Mem. Pk.		Baltimore Co. MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wm. C. March F/H 1101 E. North Ave.		JUN 3 1987		Julia Davidson-Randall				

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